

**CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT IN  
ADVANCING ADOLESCENT SEXUAL AND REPRODUCTIVE  
HEALTH RIGHTS IN KENYA: A CASE OF SIAYA COUNTY**

By

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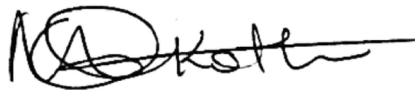
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April 2026

## DECLARATION

I, **HELLEN OKOTH MALA OWITI** (Student Number: 53315669), hereby declare that the thesis titled **"CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT IN ADVANCING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A CASE OF SIAYA COUNTY"** is my own work and has not previously been submitted by me for a degree at this or any other institution. I declare that the thesis does not contain any written work presented by other persons whether written, pictures, graphs or data or any other information without acknowledging the source. I declare that where words from a written source have been used the words have been paraphrased and referenced and where exact words from a source have been used the words have been placed inside quotation marks and referenced. I declare that I have not copied and pasted any information from the Internet, without specifically acknowledging the source and have inserted appropriate references to these sources in the reference section of the thesis. I declare that during my study I adhered to the Research Ethics Policy of the University of South Africa, received ethics approval for the duration of my study prior to the commencement of data gathering, and have not acted outside the approval conditions. I declare that the content of my thesis has been submitted through an electronic plagiarism detection program before the final submission for examination,

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## **DEDICATION**

To my parents, John Okoth Mala and Jane Strapola Mala.

## **ACKNOWLEDGEMENTS**

This doctoral journey has been one of resilience, faith, and fulfilment. I want to thank my supervisor, Prof. Gretchen Du Plessis, who coached me into academic excellence. She was present and managed me with utmost professionalism and empathy. I cannot thank you enough! I would like to extend my gratitude to the University of South Africa for the postgraduate bursary, which allowed me to focus on my academic work. I wish to extend my gratitude to the team at Siaya Muungano Network, who greatly supported my data collection process. Hilary Omondi was gracious, open to sharing information, and connecting me to the study participants. I want to thank the civil society organisations that participated in my study. They opened their doors to me and unreservedly shared their experiences. It is my fervent wish that this piece of scholarship inspires you to go over and above delivering excellent services for adolescent girls in Siaya County. My family members have helped me through my doctoral studies. My husband, Robert Owiti, thank you for bearing with my intermittent presence as I was buried in books and for cheering me on. To my children, Prince, Wendy, Trevor, Asher, and Olivier, unknown to you, you were my study partners and cheerleaders, constantly reminding me that being a 'PhD dropout' was not an option. May you find courage and inspiration to surmount all challenges in life. To my parents and siblings, thank you for the moral and financial support. My sister Esther Mala, I thank you for stepping in with childcare as I went through my academic and career journey. To my comrade, Lily Mabonga, we did it! The world is our oyster!

## ABSTRACT

This study examines the extent to which civil society organisations (CSOs) contribute to adolescent girls' reproductive justice in Kenya, focusing on Siaya County. Despite a robust constitutional and policy framework supporting adolescent sexual and reproductive health rights, significant implementation gaps persist, limiting girls' reproductive autonomy and access to comprehensive services. Grounded in reproductive justice theory, the study adopts a qualitative descriptive design. Seventeen purposively selected CSOs implementing adolescent sexual and reproductive health programmes were engaged through in-depth interviews. Data were analysed thematically to explore programming strategies, perceived barriers to reproductive justice, and factors shaping policy implementation. Findings reveal that while CSOs employ diverse interventions—such as menstrual health management, gender-based violence prevention, community outreach, and policy advocacy—these largely reflect neoliberal approaches focused on individual behaviour change rather than structural transformation. Key barriers include entrenched sociocultural norms, religious resistance to comprehensive sexuality education, gendered power relations limiting adolescent agency, and restricted access to contraceptives and youth-friendly services. Policy implementation is further undermined by weak political commitment, poor coordination across governance levels, and inadequate funding at county level. Operational constraints, including donor dependency and short-term funding cycles, further limit CSO impact. From a reproductive justice perspective, current interventions insufficiently address the rights to have children, not have children, and parent in safe environments. The study highlights how intersecting inequalities compound marginalisation and calls for a shift toward rights-based, structurally oriented approaches to adolescent reproductive health.

**Key words:** Reproductive justice, civil society organisations, Adolescent Sexual Reproductive Health, Kenya

## ABSTRACT

Lolu cwaningo luhlola izinga izinhlango zomphakathi (ama-CSO) ezinikela ngayo ebulungiswa bokuzala kwamantombazane asakhula e-Kenya, egxile eSifundazweni sase-Siaya. Naphezu kohlaka oluqinile lomthethosisekelo kanye nenqubomgomo olusekela amalungelo ezempilo ezocansi kanye nokuzala kwentsha, amagebe abalulekile okuqaliswa ayaqhubeka, anciphisa ukuzimela kokuzala kwamantombazane kanye nokufinyelela ezinsizeni ezibanzi. Ngokusekelwe kuthiyori yobulungiswa bokuzala, ucwaningo lwamukela umklamo ochazayo wekhwalthi. Ama-CSO ayishumi nesikhombisa akhethwe ngenhloso asebenzisa izinhlelo zezempilo zocansi kanye nokuzala kwentsha aye ahlanganyela ngezingxoxo ezijulile. Idatha yahlaziywa ngokwengqikithi ukuze kuhlolwe amasu ohlelo, izithiyo ezibonwayo ebulungiswa bokuzala, kanye nezici ezakha ukuqaliswa kwenqubomgomo. Okutholakele kuveza ukuthi nakuba ama-CSO asebenzisa ukungenelela okuhlukahlukene—njengokulawula impilo yokuya esikhathini, ukuvimbela udlame olusekelwe ebulilini, ukufinyelela emphakathini, kanye nokumela inqubomgomo—lokhu ngokuyinhloko kubonisa izindlela ze-neoliberal ezigxile ekushintsheni kokuziphatha komuntu kunoguquko lwesakhiwo. Izithiyo eziyinhloko zihlanganisa imikhuba yezenhlalo egxilile, ukumelana nenkolo emfundweni egcwele yobulili, ubudlelwano bamandla obulili obukhawulela i-ejensi yentsha, kanye nokufinyelela okukhawulelwe ezintweni zokuvimbela inzalo nezinkonzo ezilungele intsha. Ukuqaliswa kwenqubomgomo kuphinde kubukelwe phansi ukuzibophezela kwezepolitiki okuntekenteke, ukusebenzisana okungalungile kuwo wonke amazanga okuphatha, kanye nokuxhaswa ngezimali okunganele ezingeni lesifunda. Izithiyo zokusebenza, okuhlanganisa ukuncika kumnikeli kanye nemijikelezo yoxhaso yesikhashana, iphinde ibe nomkhawulo umthelela we-CSO. Ngokombono wobulungiswa bokuzala, ukungenelela kwamanje akulungisanga ngokwanele amalungelo okuba nezingane, ukungabi nabantwana, kanye nomzali endaweni ephephile. Ucwaino lugqamisa ukuthi ukungalingani okuhlanganayo kuhlanganisa

kanjani ukucwaswa futhi kudinga ukuthi kuguqukele ezindleleni ezisekelwe emalungelweni, ezigxile kwisakhiwo empilweni yokuzala yentsha.

Amagama angukhiye: Ubulungiswa bokuzala, izinhlangano zomphakathi, Impilo Yentsha Yokuzalana Ngocansi, Kenya

## KAKARETSO

Phuputso ena e hlahloba hore na mekhatlo ea sechaba (CSOs) e kenya letsoho hakae ho toka ea bana ba banana ba lilemong tsa bocha Kenya, e shebane le Siaya County. Leha ho na le moralo o matla oa molao-motheo le leano le ts'ehetsang litokelo tsa bophelo bo botle ba thobalano le tsa pelehi tsa bacha, likheo tse kholo tsa ts'ebetsong li ntse li tsoela pele, li fokotsa boikemelo ba banana ba ho ba le bana le phihlello ea lits'ebeletso tse felletseng. E ipapisitse le teori ea toka ea ho ba le bana, thuto e nka moralo o hlalosing oa boleng. Li-CSO tse 17 tse khethiloeng ka boomo tse kenyang tšebetsong mananeo a bophelo bo botle ba botona le botšehali ba bacha li ile tsa kenella ka lipuisano tse tebileng. Lintlha li ile tsa hlahlobjoa ka mokhoa o hlophisitsoeng ho hlahloba maano a mananeo, ho nahanoang hore ho na le litšitiso tsa toka ea pelehi, le lintlha tse bopang ts'ebetsong ea maano. Liphuputso li senola hore le hoja li-CSO li sebelisa mekhoha e fapaneng ea ho kenella-e kang tsamaiso ea bophelo bo botle ba ho ilela khoeli, thibelo ea tlhekefetso ea bong, ho buisana le sechaba, le bobuelli ba maano-tsena haholo-holo li bonahatsa mekhoha ea neoliberal e shebaneng le phetoho ea boitsoaro ba motho ka mong ho e-na le phetoho ea sebopeho. Litšitiso tsa mantlha li kenyelletsa litloaelo tse metseng ka metso, ho hanana le thuto e felletseng ea litaba tsa thobalano, likamano tsa botona le botšehali tse thibelang mekhatlo ea bacha, le ho se be le monyetla oa ho fumana lithibela-pelehi le litšebeletso tse thusang bacha. Ts'ebetsong ea maano e boetse e fokolloa ke boitlamo bo fokolang ba lipolotiki, khokahanyo e mpe ho pholletsa le maemo a puso, le khaello ea lichelete e lekaneng boemong ba setereke. Litšitiso tsa ts'ebetso, ho kenyeletsoa ho itšetleha ka bafani le nako e khuts'oane ea lichelete, li fokotsa ts'ebetso ea CSO. Ho ea ka pono ea toka ea pelehi, litšebeliso tsa hajoale ha li sebetsane ka mokhoa o lekaneng litokelo tsa ho ba le bana, ho se be le bana, le motsoali libakeng tse sireletsehileng. Boithuto bona bo totobatsa ka moo ho se lekane ho kopaneng ho kopanyelletsang khaello 'me ho hloka hore ho fetohela mekhoha e thehiloeng ho litokelo, e shebaneng le sebopeho sa bophelo bo botle ba pelehi ba bacha.

Mantsoe a bohlokoa: Toka ea ho ba le bana, mekhatlo ea sechaba, Bophelo bo Botle ba Thobalano ea Bacha, Kenya

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## LIST OF ACRONYMS AND ABBREVIATIONS

ABR	Adolescent Birth Rate
ACHPR	African Commission on Human and People Rights
ACRJ	Asian Communities for Reproductive Justice
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immunodeficiency Disease
ANC	Antenatal Care
APHRC	Africa Population and Health Research Centre
ARR	Annual Reduction Rate
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health Rights
AU	African Union
BMGF	Bill and Melinda Gates Foundation
CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
COVID	Coronavirus Disease
CRR	Center for Reproductive Rights
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
CSW	Commission on the Status of Women
DC	District of Columbia
DEI	Diversity, Equity and Inclusion
DHS	Demographic Health Survey
FDC	Four-Dimension Criteria
FGM	Female Genital Mutilation
FHI	Family Health International
FMS	Free Maternity Services
FP	Family Planning

FPAK	Family Planning Association of Kenya
GDP	Gross Domestic Product
GDPR	General Data Protection Regulations
GOK	Government of Kenya
HDI	Human Development Index
HIPAA	Health Insurance Portability and Accountability Act
HISP	Health Insurance Subsidy for the Poor
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-based Approaches
HSP	Health Service Provider
ICF	Inner City Fund
ICPD	International Conference on Population and Development
ID	Identity card
IPOA	ICPD Plan of Action
IPPF	International Planned Parenthood Federation
KCCB	Kenya Conference of Catholic Bishops
KELIN	Kenya Legal and Ethical Issues Network on HIV/AIDs
KFCB	Kenya Film Classification Board
KHIS	Kenya Health Information Systems
KICD	Kenya Institute of Curriculum Development
KNBS	Kenya National Bureau of Statistics
LAC	Latin America and Caribbean
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LMIC	Lower Middle-Income Countries
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoE	Ministry of Education
MPOA	Maputo Plan of Action
MSK	Marie Stopes Kenya

NACOSTI	National Commission for Science Technology and Innovation
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
ODA	Official Development Assistance
PAC	Post Abortion Care
PLWD	Persons Living with Disabilities
PNC	Post-Postnatal Care
PPPs	Public Private Partnerships
RJ	Reproductive Justice
SDGs	Sustainable Development Goals
SHIF	Social Health Insurance Fund
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
SRW	Substantive Representation of Women
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
SWO	Stop Work Orders
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
US	United States
USAID	United States Agency for International Development
VAW	Violence against Women
WHO	World Health Organisation

YFS

Youth Friendly Services

# **CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY**

## **1.1 INTRODUCTION**

Adolescent Sexual and Reproductive Health Rights (ASRHR) have been at the core of global development since the International Conference on Population and Development (ICPD) in 1994. It was at this conference that adolescents were identified as a core subset of the population that required specialised attention, based on their age-specific susceptibilities. Adolescent sexual reproductive health rights are a cluster of Sexual and Reproductive Health (SRH) issues specific to adolescents and backed by human rights, as articulated in normative human rights frameworks that have been duly ratified by most countries in the world. SRH rights for adolescents cover adolescent pregnancy, Female Genital Mutilation (FGM), child marriage, and Violence against Women/Girls (VAW/G), all of which have an immense impact on the social and health outcomes of adolescent girls (UNFPA & IPPF Africa 2017). This study examined the phenomenon of adolescent pregnancy as a crucial component of sexual and reproductive health rights and explored its impact on gender equality and sustainable development.

According to the World Health Organisation (WHO), 21 million girls in the developing world get pregnant, and of these, 12 million girls aged 15–19 years give birth. At the same time, the global adolescent birth rate (ABR) has reduced over the past 23 years, with a decline from 64.5 births per 1,000 women in 2000 to 41.3 births per 1,000 women in 2023 (World Health Organization 2024a). These shifts are varied across the globe, with improvements registered in Southern Asia and measured declines observed in Latin America and the Caribbean (LAC) - (52.1 births per 1000 women) and sub-Saharan Africa (SSA) (99.4 births per 1000 women). The prevalence of adolescent pregnancy in Eastern Africa is high; an assessment of Demographic Health Survey (DHS)

datasets in selected Eastern African countries placed the prevalence at 54.6% (Worku et al. 2021).

At the national level, the magnitude of adolescent pregnancy has been articulated in national surveys, such as the Kenya Demographic Health Survey (KDHS) 2022. The prevalence of adolescent pregnancy in Kenya stands at 15%, signifying a 3% drop from 2014 (KNBS & ICF 2023). At the same time, the Kenya Health Information Systems (KHIS) recorded 110,821 pregnancies between January and May 2023; of these, 6,110 were girls between 10 and 14 years old, and 104,711 were girls and women between 15 and 19 years old (Saya 2023). Factors that underlie unplanned adolescent childbearing are multifaceted and context-specific; they include lack of information on sexual and reproductive health, low use of contraception devices and sexual violence (Maharaj 2022). Incidences of unplanned pregnancies among adolescent girls in Kenya occur against a robust policy and legislative framework for adolescent sexual and reproductive health. The Government of Kenya (GOK) is a signatory to international frameworks that seek to address adolescent sexual reproductive health rights such as:

- The Convention on the Elimination of all forms of Discrimination against Women (CEDAW); and
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Kenya National Human Rights Commission 2012).

The Constitution of Kenya under *Article 43 (1)* provides that every person has the right to the highest attainable standard of health which includes the right to healthcare services (Government of Kenya 2022b). The sexual reproductive health policy framework in Kenya borrows heavily from the ICPD (1994), governed by the Kenya Health Policy 2014–2030 and implemented through the *Kenya National Adolescent Sexual and Reproductive Health Policy* (2015).

The ICPD defined reproductive health as the “*complete state of physical, mental, and social wellness in all matters relating to the reproductive system*” (UNFPA 2004: 45). This definition also encompasses the reproductive rights of a woman, covering her right to have children, the right to determine birth intervals, and access to information. Equally, the ICPD Plan of Action (IPOA) called for comprehensive reproductive health care, including family planning, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections (STIs) (UNFPA 2004). This call to action presents a compelling case for investment in adolescent reproductive health rights, from a public health, human rights, and economic perspective (Chandra-Mouli, Lane & Wong 2015).

Despite these comprehensive frameworks, many adolescent girls in developing countries, Kenya included, are far from enjoying their sexual and reproductive health rights in totality for a myriad of reasons, including tensions and discontinuities mainly propagated cultural and religious conservatism (Sidamo et al. 2023). It is worth noting that elements of adolescent sexual reproductive health, such as ending child marriage and VAW/G, have a stronger political and social buy-in as opposed to those linked to adolescent sexuality, which, in many contexts, distorts social norms and religious inclinations (Plesons et al. 2019).

Sexual reproductive health rights are linked to human rights, for instance, the right to health, life, and education. From a human rights standpoint, the state, in its capacity as a duty bearer, has a mandate to respect, protect, and fulfil them, especially:

- i. access to SRH information and services, particularly, for out-of-school adolescents and key populations.
- ii. resourcing for contraception and related services and
- iii. access to abortion services for adolescent girls (Buller & Schulte 2018).

The state has an obligation to protect SRHR, requiring that it takes steps towards third parties curtailing such rights. In addition, the obligation to fulfil SRHR

requires that the state take administrative, judicial, and budgetary actions towards realising all the SRHR as enshrined in the law (Kenya National Human Rights Commission 2012).

Civil Society Organisations (CSOs) are key players in sexual reproductive health rights and are classified as duty bearers from a rights-based perspective, as they hold resources and spaces that give them power and influence (Eghtessadi et al. 2020). In Kenya, SRH services, especially those dealing with the prevention and management of adolescent pregnancy, are delivered through government and CSOs, under the broad banner of “health programming” (Kockelkoren et al. 2023). Civil society organisations play a pivotal role in systems strengthening and policy advocacy, all geared towards effecting social change, especially for those who have been excluded and marginalised (Rusfiana & Kurniasih 2024).

Regardless of these efforts in place, by civil society organisations, gaps are still glaring in most African countries, Kenya included. There is evidence of high rates of unintended adolescent pregnancy; elevated levels of unmet needs for contraception; low implementation of adolescent sexual reproductive health policies by the governments; low access to SRH information, a lack of intersectional perspectives and approaches in the delivery of SRH services for adolescent girls, hence, the non-realisation of their rights, in general.

It is against this backdrop that this study sought to assess the extent to which adolescent reproductive justice is achieved through initiatives driven by CSOs in Siaya County, with a view of identifying their successes, opportunities, and challenges.

## **1.2 STATEMENT OF THE PROBLEM**

Research on adolescent pregnancy is often framed academically from a risk standpoint and by practitioners in the health, economic, and social sectors (Du Plessis & Macleod 2023). Resultantly, interventions towards remedying its

underlying causes and impacts are centred around public health and economic development, with a limited focus on social justice. Oronje (2013) proffers that SRH in the context of human rights remains contested, opining that there is a lack of political will to support a rights-based SRH agenda. Adolescent sexual reproductive health rights are anchored in human rights' principles of equity, denoting that adolescents should receive SRH information and services without discrimination or exclusion. The principle of accountability requires that adolescents provide feedback on the services and information they receive, which in turn assures the quality of the services received, from the relevant providers. Finally, it is essential that SRH services targeting young people are multisectoral while ensuring that there is meaningful participation of young people (Engel et al. 2019).

The wider backdrop to adolescent sexual reproductive health rights is that the so-called 'girl effect' in developmentalism has shifted the focus from women as passive victims to young women as untapped resources that can be activated as labourers, investors, peacekeepers, development agents, or consumers in neoliberal globalisation (Gonick 2006). This is predicated on the assumption of individualistic and rational agency that did not suit the context for the study. To counter the criticism against the 'girl effect', or regarding women as paradoxically both the problem (because of their biology) and the solution (because of their biology and social roles) for development, this study followed a critical approach that looked at reproductive justice as the outcome of structural, historical, cultural, community, institutional, and global forces (Engel et al. 2019; Villa-Torres & Svanemyr 2015).

Civil society organisations are key actors in the reproductive health and social justice field, where they engage as human rights defenders, advocates, and service providers at community, national, regional, and global levels (Le May & Hazelgrove-Planel 2023). Following the Paris Declaration on Aid Effectiveness, partnerships between governments, donors, and civil society organisations have been strengthened and increasingly structured (Dabelstein & Patton 2013). This

declaration offered a platform for mobilisation, lobbying, through leadership and knowledge brokering among civil society organisations and critical stakeholders engaged in sexual reproductive health and rights issues. CSOs play key roles in driving social and political change; despite this, their existence, philosophies, and operations are continuously under threat by, among others, arbitrary anti-civil society laws and curtailing of civic space by the state (Buyse 2018).

In addition, space for CSO engagement continues to shrink globally, evidenced by infringement of - rights to association, rights to peaceful assembly, freedom of expression, and systematic anti-rights and anti-gender agendas (Mcewen & Narayanaswamy 2023; Paternotte & Kuhar 2016). CSOs championing comprehensive sexual reproductive health causes, including access to safe abortion, experience opposition and attacks from organised national and transnational groups aimed at discrediting the work of SRHR organisations (World Health Organisation 2024). These factors undermine access to SRH information and services for women and adolescent girls, subsequently infringing on their capacity to make decisions over their bodies (Abdi et al. 2024). The current time is rife to critically analyse the roles of CSOs in advancing adolescent reproductive justice. This does not imply that this study has absolved the state of its responsibility in securing accessible health services; instead, the focus is on how the role of CSOs could be strengthened in this regard.

This study's theoretical framework, reproductive justice theory, (discussed in Chapter 2) lays emphasis on state accountability; nevertheless, this study's focus on CSOs is an intentional and methodologically grounded choice supported by an expanding body of African scholarship on reproductive health governance. Studies on the implementation of ASRH policies in Africa confirm that the abundant laws and policies on adolescent SRH in many countries co-occur with the state's systemic failure to deliver on its political commitments. In Ghana, Agblevor et al. (2023) found that the country's adolescent reproductive health policies were barely implemented at the point of service delivery. Similarly, Opondo, Maina, and Munyasia (2024) posit that the Kenya Ministry of Health

failed to implement its constitutional mandate to facilitate the right to health for all. Furthermore, Opondo et al. (2024) observed that the Ministry of Health worked in congruence with anti-gender and anti-rights opposition during policy development and adopted policy positions that contradicted its own health data. Based on these examples, a state focused analysis would assess the gap between policy and implementation but fail to elucidate the political bottlenecks to reproductive justice.

The principal driver of adolescent sexual reproductive health is the formal health system, found to structurally deny girls their reproductive rights leading to negative outcomes such as increased rates of unintended pregnancies and sexually transmitted infections (Yirsaw, Eshete, Tsegaye & Sidamo 2024; Sidamo et al. 2024). Prior studies have found that structural factors at the health facility level impede adolescent girls' access to SRH services and information, including provider attitudes, lack of privacy and discrimination against unmarried adolescent girls (Ninsiima, Chiumia & Ndejjo 2021; Ochieng et al. 2022; Tumlinson, Gakii, Munro-Krameer & Akenga 2022). Therefore, a study analysing health institutions would be an endorsement of a site of reproductive injustice defeating the purpose of a reproductive justice lens.

As highlighted above, CSOs are a pertinent player within the SRH ecosystem, a systematic review on the role of civil society in health in Africa identified four overlapping and unique functions that CSOs perform (Gesese et al. 2025). These roles include advocacy targeting governments and international organisations, service delivery and local and global health diplomacy, as well as holding states accountable for their commitments against rights-based standards. The accountability function makes CSOs the most relevant lens for reproductive justice, since the framework is built on the tenets of human rights and social justice. The perspectives herein affirm that the choice to study reproductive justice through the lens of CSOs work in Siaya county is founded on a theoretically and empirically grounded analytical decision.

Despite the existence of progressive adolescent sexual and reproductive health (ASRH) policies in Kenya, adolescent girls continue to experience limited reproductive autonomy due to persistent gaps between policy commitments and lived realities. Current interventions are largely framed through risk-based, biomedical, and individualised approaches, which insufficiently address the structural, sociocultural, and political determinants of reproductive injustice. While civil society organisations (CSOs) play a critical role in advocacy, service delivery, and accountability, there is limited empirical and theoretically grounded understanding of how their interventions contribute to—or are constrained in advancing—adolescent reproductive justice within complex governance and sociopolitical contexts such as Siaya County.

### **1.3 SIGNIFICANCE OF THE STUDY**

This study countered the staid notions of adolescent pregnancy as the outcome of individual choices that are removed from the socioeconomic and sociocultural environment. A feminist analysis of SRH contends that there are structural barriers to adolescent girls' agency, particularly around individual choices on their bodies and sexuality (Strode & Essack 2017). Likewise, civil society organisations are at the forefront of policy and legislative reforms on women's rights, adolescent health, and sexual reproductive health rights in, general. Interventions set up by CSOs to promote and protect the rights of adolescent girls have, for the most part, perpetuated normative discourses on early reproduction, particularly around the frame of capitalist development paradigms (Potvin 2019). This study is key in challenging the positionality and relevance of CSOs in driving social justice agenda as they navigate internal and external biases and influence, especially biopower and biopolitics that are evidenced through government policies, such as the Mexico City Policy and general restrictions implemented through institutional funding.

Whereas reproductive justice theory is rooted in American Black feminist scholarship, its application in the African development context. This study is one of the few empirical studies in Kenya to apply reproductive justice theory to interrogate CSO programming, thereby extending the theory's reach beyond its Black feminist origins in the United States.

#### **1.4 RESEARCH QUESTIONS**

1. To what extent has the robust policy and legal framework on sexual reproductive health in Kenya catalysed the promotion of ASRH in Siaya County?
2. What factors have influenced CSOs' implementation of ASRHR interventions, particularly, those linked to adolescent pregnancy, and how do they navigate challenges therein?
3. What programmatic strategies have CSOs in Siaya County deployed towards the realisation of adolescent SRH rights, in the context of adolescent pregnancy?

#### **1.5 RESEARCH OBJECTIVES**

##### **1.5.1 Primary research objective**

The primary research objective of this study was to explore and describe the contributions of CSOs in the realisation of adolescent reproductive justice in Kenya.

##### **1.5.2 Secondary research objectives**

Stemming from the primary research objective, the following secondary research objectives undergirded this study:

1. To assess the internal and external factors (structural, financial, cultural, global, institutional and gender) that influence ASRH programme interventions by CSOs in Siaya County.
2. To evaluate the effectiveness of strategies deployed by CSOs on ASRH programming in Siaya County.
3. To interrogate the influence of politics, socioeconomic and sociocultural factors, policies and laws on CSO engagement with ASRH in Siaya County; and
4. To offer policy recommendations for the realisation of adolescent reproductive justice in Kenya.

## **1.6 THE SCOPE AND LIMITATIONS OF THE STUDY**

In terms of the location of the study, the selected study site was Siaya County, one of forty-seven counties in Kenya, with a population of 993,183 in 2019, projected to increase to 1,097,141 in 2025 and 1,136,553 in 2027. Of the population, 36.6% is between 15 and 24 years old (Kenya National Bureau of Statistics 2019). There are six sub-counties in Siaya, namely, Alego Usonga, Gem, Ugenya, Ugunja, Bondo, and Rarieda, and 30 county assembly wards (County Government of Siaya 2023). The county's population primarily consists of the Luo community, with minority groups like the Luhya located in the border regions. The predominant religious belief among the people is Christianity, while Islam and many African traditional religions are also present. The primary economic activity is agriculture, which includes plant cultivation, animal rearing, and fishing (Kenya National Bureau of Statistics 2023).

Siaya's monetary poverty rate is 33.1%, marginally lower than the national rate of 35.7%. The county possesses a Human Development Index (HDI) score of 0.46, in contrast to the national average of 0.56 (Kenya National Bureau of Statistics 2023). HIV/AIDS is a major burden for households in the county. In 2022, almost half (59%) of new HIV infections in Kenya, among adolescents aged 10-19, were concentrated in ten counties. Of these, Siaya County constituted

80% of the new infections (Republic of Kenya, National Syndemic Diseases Control Council & National Council for Population and Development 2023).

The prevalence of HIV/AIDS in the area has necessitated prevention and response programming by government and non-governmental organisations (NGOs), which have targeted adolescent girls and young people. It is for these reasons that the study assessed the contribution of CSOs to the achievement of reproductive justice. Studies in the area have focused on determinants of early childbearing, school dropping out, and broader scientific research on HIV/AIDS prevention (Awuoche et al. 2024; Eilerts-Spinelli et al. 2022; Zulaika et al. 2022; Burmen, Omollo & Olilo 2019). This study was qualitative in nature, targeting a section of CSOs working in the ASRHR space in Siaya County. Data was primarily collected through in-depth interviews and with a small sample size, the study cannot claim to be representative of all CSOs in the counties or Kenya.

In terms of the limitations of the study, a small sample was selected due to the targeted nature of the study and focus on in-depth comprehension of the phenomenon. In addition, there are many CSOs in Siaya County, and it was not feasible to conduct a county-wide study. To manage this, the researcher worked through independent and knowledgeable people in the SRH sector to identify the most relevant CSOs to engage as research participants. The suitability of the theoretical and methodological decisions in terms of the findings is further explored in the last chapter of this thesis.

## **1.7 CHOSEN METHODOLOGY**

This study used a descriptive qualitative research design, as it enabled the researcher to gain an in-depth understanding of the role of CSOs in promoting ASRH. A qualitative analysis was appropriate for this study as it sought to unearth subjective experiences from CSOs, which included intangible elements, such as sociocultural issues, which could not be numerically captured (Saunders et al. 2015). Additionally, a qualitative research design takes a naturalist standpoint,

seeking to understand phenomena in their contexts without an attempt to manipulate the topic under investigation.

This study sought to understand the contribution of CSOs to adolescent sexual reproductive health, hence, a positivist approach with a pre-existing hypothesis did not suffice. Instead, a qualitative approach allowed for the generation of knowledge based on organisations' programming experiences and learnings (Young & Atkinson 2012). This study was transformational in nature, with a desire to offer policy proposals for the realisation of adolescent reproductive justice. The study targeted national and international CSOs programming around SRH, with a specific focus on adolescent girls in Siaya County. Specific details on the research design, sampling techniques, data generation, and data analysis strategies are discussed in Chapter Three of the thesis.

## **1.8 CHOSEN THEORETICAL FRAMEWORK**

The study was informed by the reproductive justice theory, which the Asian Communities for Reproductive Justice (ACRJ) define as "*physical, mental, spiritual, political, social, and economic well-being of women based on the full achievement and protection of women's human rights*" (Ross 2020: 1). It is based on three interconnected human rights, which are:

- The right to have a child under the conditions of one's choosing.
- The right not to have a child using birth control, abortion, or abstinence.
- The right to parent children in safe and healthy environments free from violence by individuals or the state (Ross 2020: 2).

The reproductive justice theory recognises that women's rights, especially SRHR, are influenced by individual, community, and structural factors that prop up gender inequality (Crawford et al. 2023). The ACRJ suggests that reproductive justice be embraced from three angles, namely:

1. Reproductive health to cover service provision and delivery.
2. Reproductive rights with a focus on addressing legislation and legislative issues.
3. Reproductive justice with a focus on social movements that rally a critical mass of people agitating for the rights of women (Ross 2007: 290).

According to Ross (2007), reproductive justice is not prescriptive in any way but would have the following characteristics:

- a. Appreciating the central notion of intersectionality
- b. being anchored in a human-rights framework
- c. addressing power relations
- d. linking micro- and macro-level issues
- e. addressing government and political issues.

Key to the reproductive justice theory is the need to continuously challenge stayed assumptions around hegemonic femininity, where, in this case, motherhood is assumed to occur in a linear and hierarchical manner, preferably planned, in marriage and with the requisite support provided throughout the pregnancy period (Thakkilapati 2019). Linked to this is a recognition that Kenyan law, under this context, is restrictive to the extent that adolescents are seen as children, therefore, deemed not to have the capacity to make choices on their sexual and reproductive health (Kangaude & Skelton 2018).

CSOs work and deliver programmes in a complex system, impacting heavily on the ability of adolescents to enjoy their SRH rights. Using an alternative lens, this study assessed how CSOs deployed their capacity to support adolescent girls' SRH rights, before, during, and after pregnancy. The use of reproductive justice theory as a framework of analysis, for access to reproductive rights, in a neoliberal context is crucial as it recognises other factors that have implications on the enjoyment of those rights. Wilson (2018) argues that under the Malthusian perspectives on population control, where poverty is linked to the poor and not

necessarily the capital and systems, continue to inform programmes targeting adolescent girls. Globally, for instance, programmes such as Nike's *Girl Effect*, Plan International's *Because I am a Girl campaign* and the World Bank's *Adolescent Girl Initiative* programmes are influential in targeting adolescent girls. Reproductive justice provides a suitable framework to assess the tensions between social justice and economic principles and how they combine to promote gender equality.

Through a reproductive justice approach, the rhetoric of reproductive choice is critically examined, unearthing the bottlenecks in the system and within programming approaches, as far as adolescent reproductive rights are concerned (McKee 2018). It is critical to note that access to SRH services as public goods is not only influenced by government and CSOs, but also by markets with the rise in philanthro-capitalism through public-private partnerships (PPPs), such as the financing of Family Planning 2030. This demonstrates that the political economy influences CSO engagements and largely assesses enabling factors, such as power dynamics and how CSOs circumvent those hurdles (Butler 2019; Bendix & Schultz 2018; Birn 2014).

The tenets of the theory are fully explored in Chapter 2 and the suitability of the theory expounded in the last chapter of the thesis. Reproductive justice theory was deemed most suitable for this study, as it is anchored in human rights approaches and acknowledges that intersectionality is critical when investigating the realisation of rights. CSOs have an implementation and influencing role, hence, the framework proposes approaches that link local and global-level work, as well as, service delivery and legislative reform and implementation, in addition, to raising voices for change through movement building and social mobilisation.

## **1.9 CLARIFICATION OF KEY TERMS**

### **Adolescents**

This study adopts the WHO definition of adolescents as people between the age of 10 – 19 years (World Health Organization 2024a).

### **Civil Society Organisations**

This study defines civil society organisations as any non-state, non-market institutions operating within a formal registration in Kenya and advancing social development objectives. CSOs are non-profit and non-state organisations outside of the family or clan in which people organise themselves to pursue shared interests in the public domain (Co-operative for Research and Education and the Institute for Democracy in South Africa 2001). CSOs balance state power and provide opportunities for democratisation because they are independent and have an autonomous nature.

### **Adolescent Sexual and Reproductive Health**

This study adopts the ICPD definition of reproductive health as, “*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes*” (UNFPA 2008: 6).

### **Neoliberalism**

Neoliberalism is the idea that political and economic institutions should be liberal and capitalist (Vallier 2026). This study invokes the term neoliberalism in relation to the shifting role of the state in providing sexual and reproductive health services to women and girls. In the context of adolescent SRH, this often manifests as social development interventions that promote a one-size-fits-all approach, including behaviour change with a focus on structural and systemic transformation of socioeconomic, political and legal environments that shape adolescent girls’ reproductive lives.

### **Intersectionality**

Intersectionality is a theoretical framework suggesting that various social positions (such as race, gender, socioeconomic status, sexual identity) intersect to create a specific context for health and social experiences (Crenshaw 1989; Collins 1990). Stemming from the understanding that experiences at those intersections are influenced by larger interpersonal and structural systems of oppression of racism and sexism (Bowleg 2012; Collins 1995), this study defines intersectionality as the multiple factors and systems of discrimination and oppression that influence how adolescent girls access their sexual reproductive health rights and how they exercise their bodily autonomy.

### **Devolution**

This study defines devolution as the constitutional transfer of legislative and financial authority from the national government to the 47 semiautonomous county governments after the promulgation of the Constitution of Kenya.

### **Reproductive autonomy**

This study defines reproductive autonomy as the capacity of an adolescent girl to make informed decisions regarding their bodies, fertility and sexuality without duress, manipulation and systemic constraints. including legal blocks (Purdy 2006).

### **NGO-isation**

This study defines NGO-isation as the structural transformation of community and civil society activism into professionalised, institutionalised and donor-driven institutions (Ungsuchaval 2016).

## **1.10 THE STRUCTURE OF THE THESIS**

Chapter One introduces the problem under study, outlining - the background to the research problem and stating the purpose, objectives of the study and research questions, with a brief description of the research design and methodology. The literature reviewed on adolescent sexual reproductive health, CSO engagement in the implementation of policy and legislative framework on ASRH, is presented in Chapter Two. The chapter will also provide an overview of the theoretical framework within which the study has been framed. Chapter Three outlines the research methods and methodologies used in this study and the rationale for the research methods employed; it describes the research process involved, including the process of data analysis. A description of the study area is provided and data collection methodologies explained, covering their limitations as well. Ethical considerations are also discussed. In Chapter Four, an analysis of the findings from the data collected and a discussion of the results against what other researchers have found are presented. In the final chapter, Chapter Five, the researcher presents the study conclusions, limitations and recommendations.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

In the first section of this chapter, the researcher provides an overview of adolescent sexual and reproductive health rights as articulated in global and regional human rights' frameworks and within Kenya's policy and legislative framework. Such frameworks lay out the commitments of the government of Kenya towards the delivery of adolescent SRH that all actors, including civil society organisations, can engage with. The discussion of the frameworks is followed by an evaluation of factors, suggested by existing research, as influencing the implementation of the frameworks in Kenya. Access to ASRH information and services through youth-friendly services are the special foci for this section of the chapter.

In the third section of the chapter, the researcher elaborates on civil societies' role in adolescent sexual reproductive health with a focus on their engagements in family programming. The review of literature, for this third section is on the evolution of civil society and civil society organisations as key agents in participatory development.

In the final section of this chapter, the researcher introduces reproductive justice as the theoretical framework that underpins this study. The researcher discussed the history, application and debates around reproductive justice. Here, the application of the reproductive theory within African feminist thought is explored, critiques from scholars and practitioners on reproductive justice theory are discussed , and proposals are advanced on how to bridge these limitations.

## 2.2 GLOBAL AND REGIONAL PERSPECTIVES ON ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

The Guttmacher-Lancet Commission defines sexual and reproductive health as “*a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction*” (Boyer 2018:36). The definition combines four concepts - sexual health, sexual rights, reproductive health and reproductive rights – which are all anchored on individuals’ - right to bodily autonomy, choice of their sexual partners, access to information that would facilitate decision-making, and the right to have or not to have a child. Even though these rights are well laid out in statutes and policies, at global and national levels, their fulfilment and enjoyment are contingent upon sociocultural factors as well as political goodwill, from local to global levels (Tallarico 2020). Since the ICPD, there have been considerable advancements in SRHR with regards to maternal health and recognition of SRH as a human rights issue, including the rights of persons living with disabilities (PLWD) (Otu et al. 2021; Sen et al. 2019; Shakespeare et al. 2019).

According to the WHO, there was a significant decrease in maternal mortality from 2000 to 2015, with the global maternal mortality ratio (MMR) (SDG indicator 3.1.1) falling by one-third, from 339 to 227 deaths per 100,000 live births. By 2020, the global MMR had decreased to just 223 deaths per 100,000 live births. Whilst these global metrics point to progress toward SDG targets, constant disparities in Africa reveal that international policies often fail to circumvent local barriers. Africa held the highest rates of MMR over the two decades despite a continued decline marked by an annual reduction rate of 2% (World Health Organisation 2024).

In 2023, the global ABR was 41.3 births per 1000 girls aged 15–19 years, representing a 36% decline since 2000 and a 12% since 2015. Among girls aged

10–14 years, the global ABR declined from 3.3 in 2000 to 1.8 in 2015 and 1.5 in 2023. Comparatively, the European and Western Pacific continents maintained the lowest ABR and the lowest proportion of births among adolescent girls in relation to all births, while the African continent continued to have the highest levels (World Health Organisation 2024). These negative trends not only reflect on clinical failures but also on the moral friction around sexual reproductive health and rights.

On the same breath, maternal mortality rates have improved globally, although morally contentious subjects within sexual reproductive health, such as the sexual rights of minors, abortion rights, comprehensive sexuality education and the provision of SRH services to minors, continue to face opposition (Brown et al. 2019). According to the UN's first independent expert on protection against violence and discrimination based on sexual orientation and gender identity, over 70 countries around the world prohibit same-sex marriage, with some African and Asian countries, such as Sudan and parts of Nigeria, imposing the death penalty (United Nations 2024). Prejudice and discrimination based on sexual orientation, arbitrary arrests and killings, and limited access to SRH services, are just a few of the challenges LGBTQI+ people confront (Ploszka 2022; Pincock 2021).

Resistance against LGBTQI+ rights around the world, and Africa in particular, happens against a backdrop of international norms and normative frameworks that are not actualised locally, due to political retorts and cultural sensitivities, defying the actual spirit of the ICPD (Izugbara et al. 2020; Nduna et al. 2017). It is worth noting that experiences of sexual minorities differ depending on the contexts in which they find themselves; for instance, a study conducted in South Africa found that adolescents from sexual minority groups face multiple levels of discrimination as they attempt to access SRH services due to societal attitudes on sexuality (Francis et al. 2019). At the same time, organisations set up to support adolescent sexual minorities fail to meet their objectives for fear of being branded 'homosexual recruiters' (Müller et al. 2018).

The core principles of the ICPD are still being contested, especially regarding how to meet the strategic needs of adolescents (Okonofua 2024). The tension between international normative frameworks on human rights and local opposition fundamentally influences how all adolescents are perceived by the state. By pathologising adolescence as a problematic period instead of a developmental stage, adolescents' agency and bodily autonomy is stripped off (Njagi 2023). These perspectives influence legislation, policies, and practices around SRH, challenging the very essence of the ICPD (Tallarico et al. 2021).

There are 1.2 billion adolescents in the world, accounting for 16 per cent of the global population and 23 per cent in Sub-Saharan Africa. It is estimated that 1.2 million adolescents die each year from preventable and treatable illnesses (Shinde et al. 2023). Maternal health issues are among the leading causes of death among adolescent girls aged 15 to 19, with at least 15 per cent of girls giving birth before the age of 18 and approximately ninety-nine per cent of maternal deaths among adolescents occurring in lower-middle-income countries (LMICs) (World Health Organisation 2024c). Regional and socioeconomic circumstances may bring in some variances, however, studies indicate that girls between the ages of 15 and 19 are predisposed to increased risk of pre-eclampsia and eclampsia, haemorrhage, and sepsis, just as older women (Ajayi et al. 2023).

Access to safe abortion services is a critical component of maternal health and SRH, but they remain marred in sociocultural, moral, and religious controversies that prevent the development and implementation of relevant policies (Dias et al. 2021). Unsafe abortions are frequent around the world, with an estimated 25.1 million conducted between 2010 and 2014, with a higher rate of 49.5 per cent in poor countries with strict abortion laws (Faundes et al. 2020). According to the World Abortion Laws Map, abortion is outlawed in twenty-four countries around the world, limiting the reproductive rights of around 90 million women. Only forty-two countries allow abortion when a woman's life is in danger. Other legal grounds used to prevent females from accessing their rights include maintaining

a woman's health, socioeconomic realities that may have an impact on the unborn child's survival, and the gestation period (Centre for Reproductive Rights 2019).

Consequently, while some women of reproductive age live in nations where they can access abortion services, others live in contexts where abortion laws are extremely restricted, limiting their bodily autonomy and agency. The complexities around access to safe abortion services operate against the backdrop of low uptake of maternal health services, particularly among pregnant adolescents, for varied individual, societal and systemic reasons (Mekonnen et al. 2019). To illustrate this, a study conducted in South Africa found that factors, such as race and class impeded access to services, prompting adolescents to resort to unsafe procedures (De Wet 2016).

This study focused on adolescent pregnancy as a sexual reproductive health rights issue for three reasons. Firstly, pregnancy entails antenatal, perinatal, birth and post-natal care. As an unplanned pregnancy for an adolescent girl may be her first contact with SRH services, it further entails family planning information and services and might also include termination of pregnancy services or HIV testing. Secondly, societal attitudes regarding early pregnancy and childbearing are influenced by perceptions about the age of consent, socioeconomic status, problematisation of the adolescence period and gender norms. Thirdly, unplanned adolescent pregnancy can be stigmatised and pathologised in terms of its impact on the economy, being seen as deviance from social norms and risks to the health of the mother and baby. The researcher framed adolescent pregnancy within a human rights perspective, thereby looking at structural and systemic issues that intersect to shape the impact on pregnant adolescent girls' socioeconomic outcomes.

The context within which adolescents' SRH rights play out has significantly evolved following the ICPD. Firstly, in demographic terms, the number of adolescents grew from 1.1 billion in 1994 to 1.3 billion in 2025, making up 16% of the world's population (Education Cannot Wait 2025). The world has become

more urbanised, with 56% of the population living in urban areas, and globalisation has led to increased connectivity in the information age and social media. Education opportunities have increased, fertility rates have decreased, and world poverty has decreased, but inequality is at an all-time high in developing countries (Aerts 2018). Secondly, at the global level, the Millennium Development Goals (MDGs) were developed in the year 2000 but did not specifically address the health of adolescents and young people as a standalone development goal (Agyei & Johnson 2019). At the time, the role of sexual reproductive health in improving global health was unclear, especially its contribution to maternal health and economic and gender empowerment (Galati 2015). The MDGs were later succeeded by the Sustainable Development Goals (SDGs) in 2015, recognising sexual reproductive health as a development issue under Goal 3 (Health), Goal 4 (Education) and Goal 5 (Gender Equality) (Otieno et al. 2024). The nexus between the SDGs and ASRH is crucial in global and national development; from a planning standpoint, targets have been set for services under indicators 3.1 and 3.7 and barriers to SRH and human rights covered by indicator 5.6 (UNFPA 2024). The SDGs provide an essential global backdrop for international development by influencing how donors and governments deploy human and financial resources up to 2030 (De Silva et al. 2024).

The ICPD provides a universal framework for adolescent SRH rights, establishing language for bodily autonomy and reproductive agency and is reinforced by a regional policy architecture. Foremost is the Maputo Protocol (the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa), which translates international standards into the African context. It explicitly recognises reproductive rights as human rights, including the right to control fertility and access safe abortion under specific conditions (African Union 2005). Article 14 offers the right to health and reproductive services for women and girls: to control their fertility, choose any method of contraception, plan the spacing of births, and receive reproductive education (Sithole & Dziva 2019).

This is undergirded by the *AU Strategy for Gender Equality and Women's Empowerment (2018-2028)*, which seeks to amplify women's agency and dismantle barriers to health and security. (African Union Commission 2018). To ensure accountability the African Commission on Human and People Rights (ACHPR) serves as a protective mandate with a Special Rapporteur on the Rights of Women in Africa tasked with state compliance and reporting as well as developing guidelines for human rights reporting.

The Maputo Protocol is operationalised through the Maputo Plan of Action (MPOA) which specifically targets the reduction of maternal mortality and the expansion of adolescent-friendly services to meet the continent's demographic dividend (African Union Commission 2016). The transition from these high-level African Union commitments to localised implementation is not without challenges (Plesons et al. 2019). Mama (2020) contends that African states activate legal frameworks to harbour women's and girls' reproductive rights within patriarchal and economically punitive jurisdictions. Consequently, African states' selective ratification of these normative frameworks is indicative of a structural mechanism that aligns with progressive norms while preserving their discretion to limit their operationalisation at the domestic level.

Despite 44 out of the 55 AU member states having ratified and acceded to the Maputo Protocol, adolescents face systemic hurdles such as legal requirement for parental consent to SRH services, criminalisation of abortion services even within legal provisions and denial of school re-entry after pregnancy (Solidarity for African Women's Rights 2023). Studies at the continental level have shown that implementation gaps persist due to poor awareness of these legislations, clashes between the liberal ideas of these instruments and actual gendered social norms, high donor dependency, lack of political goodwill and limited financial resources for implementation (Mwoka et al. 2021).

The following section discusses the implementation of Kenya's reproductive health laws and policies with a focus on the access to SRH services and information.

### **2.3 POLICY VERSUS PRACTICE : IMPLEMENTATING REPRODUCTIVE HEALTH RIGHTS FRAMEWORKS IN KENYA**

Significant normative tension characterises the translation of the regional mandates discussed in Section 2.2 into Kenya's domestic landscape. Even though Kenya ratified the Maputo Protocol, it has historically maintained reservations under Article 14(2)(c) on medical abortion on the grounds of rape, sexual assault and endangering the mother's mental and physical health, citing inconsistencies with its domestic laws. This legal dissonance weakens progressive regional standards on bodily autonomy in favour of restrictive national interpretations, creating a fragmented socio-legal environment. Kenya's domestic SRH framework, anchored by the 2010 Constitution, functions as a contested terrain where the state concurrently affirms reproductive health as a right while implementing policies that effectively curtail adolescent reproductive agency.

Article 43(1)(a) affirms that everyone has a right to the highest-level health possible, including reproductive health care (Government of Kenya 2022). On the other hand, Section 6 of the Health Act (2017) states that every person has the right to reproductive health care, which includes the right to safe family planning services for men and women of reproductive age; the right to access appropriate health care services and access to treatment by a trained professional (Government of Kenya 2017). The *Kenya Health Policy 2014 - 2030* places a strong emphasis on participatory multi-sectoral and social accountability mechanisms, equity, and people-centredness, in the delivery of health services (Republic of Kenya 2014). This policy issues guidance for the administration and operations of the healthcare services, following the decentralised system of

governance in Kenya after the promulgation of the 2010 Constitution. The policy assumes a rights-based approach to health, laying emphasis on inclusive, participatory and equitable provision of services, particularly for the vulnerable ones, including persons living with disabilities and adolescents.

Kenya developed its first *Adolescent Sexual Reproductive Health and Development Policy* in 2003, followed by a revision in 2015 with the following objectives:

*“Promotion of partnership among adolescents, parents, and community. Creation of an enabling, legal and sociocultural environment that promotes provision of information and services for adolescents and youth. Promotion and protection of adolescent reproductive rights. Strengthening inter-sector coordination and networking in the field of adolescent health and development”* (Republic of Kenya 2015:3).

The policy adopts a multi-sectoral approach, providing indicative roles and responsibilities for all actors, including CSOs, covering:

- Provision of SRH information and services.
- Research, ASRH policy making and dissemination.
- Building community and stakeholder support for ASRH policies and programmes.
- Supporting sustainable programmes that seek to empower adolescents.
- Engagement of adolescents in policy formulation and programme design.
- Resource mobilisation for policy implementation (Republic of Kenya 2015: 31).

This policy operates off the back of the *National Reproductive Health Policy 2022–2032*, which seeks to integrate universal health coverage (UHC), domestic health financing and an increased focus on populations, such as adolescents

(Republic of Kenya 2022). This policy identifies adolescent health, gender-based violence, maternal and child health and family planning as special focus areas. Just like the *Kenya National Adolescent Sexual Reproductive Health Policy 2015*, the policy identifies low levels of funding and low prioritisation of reproductive health issues as blockers to the full enjoyment and access to sexual reproductive health rights in Kenya.

It is worth noting that the constitutionality of the *National Reproductive Health Policy 2022–2032* is in question, as it failed to go through public participation where the Kenyan public and interested parties would have had an opportunity to reflect on the true needs and realities surrounding sexual reproductive health in Kenya. Additionally, this policy introduced unreasonable expectations around the need for parental consent for adolescents, which would further exclude them from access to SRH services (KELIN 2023). Moreover, the policy contends that complete cognitive ability regarding sexuality and reproduction starts at age 21, and it prioritises delayed sexual debuts and abstinence for individuals who have not yet reached full cognitive competency (Aoko 2022).

Another policy framework linked to adolescent sexual reproductive health rights is the *National School Health Policy (2009)*, whose premise is to improve the health and education of school-aged children, acknowledging that health is vital for effective learning. This policy was jointly developed by the Ministry of Public Health and Sanitation and the Ministry of Education, aiming to establish healthy and safe learning environments. The policy sought to safeguard child rights and gender issues in a school setting whilst fostering positive values in learners. Underpinning this policy are the principles of equity and non-discrimination in the provision of health services and education in Kenya (Republic of Kenya 2009). Further, the *National Guidelines for the Provision of Adolescent and Youth Friendly Services (2016)* detail fundamental frameworks and tactics for providing reproductive health services customised to the requirements of adolescents and young individuals aged 10-24 years. This policy sets out different service delivery modalities, including school-based, facility-based, and community-based

methods, with an overarching focus on addressing the sexual and reproductive health risks that adolescents and young people face.

The foregoing discussions have outlined Kenya's contradictory policy and legislative environment. The frameworks discussed are anchored on rights-based rhetorics with a focus on equity and access, other policies adopt a protective approach that obstruct adolescent girls' reproductive autonomy. Having framed the political and legislative context underpinning adolescents SRH rights, the forthcoming section discusses access to SRH information and services as essential progressions towards actualisation of the legislative and policy frameworks. .

### **2.3.1 Access to SRH information**

Access to SRH information is a human right articulated in various international, regional and national instruments, including the ICPD Plan of Action, Article 35: on the right to information in the Constitution of Kenya (Government of Kenya 2022b). The *Kenya National Adolescent Sexual Reproductive Health Policy* (2015) envisages the provision of holistic and comprehensive information through multi-sectoral approaches. Nevertheless, open access to SRH information has been curtailed, often due to moral or religious dissenting voices which argue that access to such information would spur adolescents to indulge in sex (Obare, Odwe & Birungi 2016). The reality is that Kenyan adolescents have sex at early ages, as evidenced by the fact that 21.5% of youth report having had sexual intercourse prior to turning 15. This figure is notably higher for adolescent boys and young men at 30.3% in comparison to adolescent girls and young women at 12.6% (Langat et al. 2024). Overall, the denial of SRH information and services based on the notion that it would encourage promiscuity does not have an empirical base, hence, amounts to discrimination and a violation of adolescent girls' right to information (Durojaye 2019).

Access to SRH information empowers adolescents, as it facilitates knowledge acquisition, attitude and behaviour change, which would result in favourable health choices and outcomes (Centre for Reproductive Rights 2021). The acknowledgement of adolescents and context-specific factors, including sociocultural beliefs and practices regarding sexuality, political considerations, and legal constraints, determine the extent to which SRH information is accessed (Langat et al. 2024). Concerning individual preferences, friends and parents have been identified as the main sources of information in certain contexts. A study conducted in Ghana among in- and out-of-school adolescents aged 10–19 years found that most participants had limited knowledge on SRH health and options and that they largely relied on peers for information (Kyilleh et al. 2018). Similarly, research carried out in Rwanda examining key informants' perspectives on the facilitators and obstacles to adolescents' access to SRH information argued that adolescents' curiosity around sexuality matters led them to seek SRH information from multiple sources, including leaning towards celebrities for information (Mbarushimana et al. 2022).

Regarding parents being a source of SRH information, research points out the polarities around their capacity and willingness to share accurate SRH information (Bweyale & Sekaye 2023; Mbarushimana et al. 2022). A study evaluating the SRH knowledge and experiences of young women aged 18–24 years in Soweto, South Africa, noted that parents were aggressive in SRH discussions and generally uncomfortable to engage with their children (Lince-Deroche et al. 2015). Another study conducted in a South African peri-urban community indicated that some parents did have SRH conversations, however, the conversations took a punitive approach where an emphasis on adolescents' education was preferred (Gillespie et al. 2022). Even though parents are seen as essential in promoting conversations about sex and sexuality, their ability to provide SRH information accurately and objectively has been questioned, and recommendations for parental capacity-building have been made (Ganji et al. 2017).

In addition to parents and peers, adolescents receive SRH information through health facilities, however, the uptake of these information services is influenced by the health-service providers' attitudes as well as infrastructure status (Sidamo et al. 2024). A study in Tanzania reviewing the accessibility of SRH information among marginalised and young people found that access to SRH information was generally high but significantly lower amongst younger adolescents aged 10–14 years, reaffirming that adolescents are not a heterogeneous group and that nuanced programming approaches are required (Ngilangwa et al. 2016). Adolescents interviewed in the coastal area of Kenya indicated that they found it challenging to access information from public health facilities due to long waiting times, and they were uncomfortable seeking information from older male health-service providers (Langat et al. 2024).

Policies point out the role of health service providers in delivering SRH information and services to adolescents and young people, studies have found that some HSPs lack the training and capacity to deploy adolescent-friendly information and services, effectively (Ochieng' et al. 2022; Gausman et al. 2021). Relevant HSP capacity to deliver SRH information is described as the ability to communicate in a non-judgemental manner and the provision of an environment that enables conversations (Mazur et al. 2018; Mazur et al. 2024). In relation to supportive infrastructural contexts, studies have shown that adolescents prefer health facilities that provide privacy, shorter waiting times and accessibility on the weekends (Ochieng et al. 2022; Mazur et al. 2018).

In recent times, digital technologies have revolutionised how young people access information regarding their sexual reproductive health. To begin with, digital platforms have a greater reach, allowing for specialised messaging for targeted audiences (Bacchus et al. 2019). In addition, digital platforms are crucial in empowering young people without gatekeeping by health service providers or parents who often are biased based on their cultural and religious inclinations (El Fakahany & Ibrahim 2024). A study conducted in Jordan found that adolescents preferred to obtain information online because they were concerned that

reproductive health clinics would not accept young, unmarried women seeking information (Al-Shdayfat et al. 2019). Digital platforms, therefore, are preferable due to the anonymity they offer to young individuals, particularly those who are transitioning from traditional channels. A study conducted in the Reunion Islands, assessing the feasibility of sexual health and contraceptive teleconsultation through web services, affirmed that confidentiality and privacy were great needs of young people, therefore, paramount in the design of SRH services (Reynaud et al. 2024)

There are diverse opportunities that digital technologies present for access to SRH information, despite this, challenges continue to prevail. Firstly, technical shortcomings, such as poor internet infrastructure are commonplace. To illustrate this, a study from Afrobarometer indicates that 84% of Africans on the continent own a mobile phone, although only 45% have access to the internet. Furthermore, population groups that have lower access to the internet are women, rural populations and those with lower levels of education. At the same time, the study indicates that only 28% of the African population have a computer in the household, and only 40% indicated that they accessed the internet via phone or computer a few times a week (Malephane 2022). These disparities showcase the extent to which digital inequality exists and influences access to SRH information, especially for women and rural populations. Njagi (2023) showcases gender disparities where digital SRH programmes that were designed to offer SRH information to adolescents of all genders disproportionately attracted male users. One of the root causes of these inequities was gendered norms where girls were discouraged from using the internet to protect them from predatory experiences.

The era of digitalisation, secondly, continues to initiate a multitude of platforms, including social media applications and websites, which unfold on a continuous basis. This poses challenges of misinformation and disinformation, especially where there are limited regulatory safeguards and quality assurance processes (Mills et al. 2023). At the same time, where there are regulations around data

protection and privacy, such as - the General Data Protection Regulations (GDPR) in Europe; the Health Insurance Portability and Accountability Act (HIPAA) in the United States and national laws such as the Data Protection Act (2019) in Kenya - the reality is that the digital world is borderless, making it difficult to regulate without concerted efforts by different stakeholders (Bisola et al. 2024).

As indicated above, SRH information among adolescents is relayed via digital platforms, at family and community levels, as well as within institutions. On the institutional front, SRH information is relayed to adolescents through Comprehensive Sexuality Education (CSE), which is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality (Ogolla & Ondia 2019). As a multidimensional strategy, CSE emphasises the importance of dissemination of correct information; the acquisition of life skills; and the promotion of good attitudes and values towards sexuality (Awusabo-Asare et al. 2017). In Kenya, CSE is promoted through multiple health and education policy frameworks, including the *Kenya National Adolescent Reproductive Health Policy* (2015), *Education Sector Policy on HIV/AIDS* (2013) and *Policy Framework for Education and Training* (2004). The Ministry of Education (MoE), through the Kenya Institute of Curriculum Development (KICD), is mandated to develop a curriculum in consultation with stakeholders, including teachers and civil society organisations (Sidze et al. 2017). In this context, comprehensive sexuality education is delivered through school programmes and mass media projects supported by international and civil society organisations (African Union Commission 2016).

Comprehensive sexuality education is centred on the principles of age appropriateness, adoption of a human rights approach, comprehensiveness, and cultural relativism (UNESCO 2018). The delivery of a rights-based sex education, however, is contentious, as what is deemed culturally appropriate differs across contexts. Additionally, children are constructed as weak and asexual, necessitating protective and risk-based policies and interventions (Zulu et al. 2019). These perspectives have influenced the delivery of comprehensive

sexuality education in Kenya; for instance, a review of the implementation of CSE in Kenya revealed that the curriculum was focused on life skills, biology and Christian religious education with emphasis on abstinence. The Kenyan approach was found to be deficient in critical sexual reproductive health issues, such as contraception, abortion, sex, and sexual health (Sidze et al. 2017). Similarly, curriculums delivering CSE were found to be wanting, as they were facilitated by generalist teachers with personal biases and ideologies on sex and sexuality without technical capacity and training on values clarification and unconscious bias, making the whole process, rather, defeatist (Ogolla & Ondia 2019).

Comprehensive sexuality education is intended for children and young people in and out of school, although the school-focused activities are more structured, as there exists a curriculum and schedules in the calendar. On the other hand, out-of-school engagements require more innovations and flexibility, as their delivery is hampered by operational and contextual issues such as access to convenient engagement settings and the availability of training materials and supplies (UNESCO 2018). Comprehensive sexuality education targeting out-of-school children is critical given their large numbers. Notably, there are 258 million adolescents and youth out of school, of which 114 million are in sub-Saharan Africa (UNESCO Institute of Statistics, 2019). According to the 2021 report from this same Institute, there are approximately 1.8 million children and adolescents in Kenya between the ages of 6 and 17 who are not enrolled in school (UNESCO 2021). The justification for out-of-school children's access to SRH information is rooted in human rights principles of non-discrimination and equality, calling on the ability of duty bearers to take steps to ensure that all children have access to accurate and comprehensive information about their sexuality, allowing them to achieve positive socioeconomic outcomes (UNICEF 2018).

The role of CSE in advancing SRH information is critical, yet obstacles proliferate from an ideological, sociological and political standpoint (Wangamati 2020). Efforts have been made to halt the comprehensive and widespread

implementation of sex education on religious, moral, and sociocultural grounds. Opponents such as the Kenya Conference of Catholic Bishops (KCCB) have long held that CSE destroys the moral fibre of the country (Kahiu 2020). In collaboration with Family Watch International, the KCCB led an online campaign to force the government to end CSE. Others have referred to CSE as “soft porn”, citing the inclusion of topics such as masturbation and same-sex relationships as immoral (Head 2020). Family Watch International (2020) pushed back on CSE's legitimacy, claiming that it is based on flawed research and has a hidden agenda to promote abortion and LGBTQI+ rights (Slater n. d.). In opposing the delivery of CSE, other opponents opine that topics such as sexual pleasure, sexual orientation, gender identity, access to contraception, and abortion services are harmful to young people's health (Gennarini et al. 2016). These divergent views on the impact of CSE from an ideological perspective are far removed from a rights-based focus. Panchaud et al. (2019) studied existing policy frameworks on CSE in Africa and Latin America, concluding that programmes that were rights-based and challenged social norms and gendered biases, improved young people's confidence, self-esteem, and agency.

In addition to the ideological contestations that comprehensive sexual education faces, the broader model has been challenged from a strategy perspective. Notably, studies have found that CSE programmes have failed to demonstrate the impact on the lives of adolescents due to piecemeal delivery of information and services, which in turn is due to inconsistent and limited funding from government (Chandra-Mouli et al. 2024). In instances where funders support CSOs to deliver CSE, the preference is often for individual specialised curricula as opposed to delivering the government-sponsored one, resulting in a lack of coordination (Chandra-Mouli et al. 2015). Additionally, the exclusion of adolescents' and young people's voices in the CSE debates is counterproductive, and the imposition of ideological and parental views jeopardises the effectiveness of the model (Wood & Hendricks 2017; Denno et al. 2015).

Comprehensive SRH information is impeded by administrative actions and government constraints. In 2018, the Kenya Film Classification Board (KFCB) banned Marie Stopes Kenya (MSK) from providing reproductive health information for allegedly promoting abortion through radio campaigns. The Kenya Medical Practitioners' and Dentists' Board banned MSK from providing Comprehensive Abortion Care (CAC) and Post Abortion Care (PAC) (Centre for Reproductive Rights 2021). The curtailment of accurate information is detrimental to the provision of quality SRH services, as it perpetuates misinformation on SRH issues such as contraception and abortion. Similarly, a study conducted by the Centre for Reproductive Rights (CRR) in Kenya across five counties found that county and the national government lacked public information services on reproductive health and only women and girls with access to CSOs were able to counteract popular myths around contraception (Centre for Reproductive Rights 2021).

The foregoing paragraphs have demonstrated that access for adolescents to SRH information is influenced by individual preferences and socially accepted narratives around sex and sexuality, as well as political and religious bigotry. Further, access to information is driven from a risk-based perspective, as such, CSE policies and programmes aim to promote good values and mitigate any foreign agenda and influences. Unfortunately, the needs of adolescents are not considered in the design and delivery of SRH information and services, and these impede their capacity to receive relevant information and make informed decisions over their lives.

### **2.3.2 Access to SRH services**

Sexual reproductive health services linked to adolescent pregnancy cover a broad range of interventions - counselling and provision of contraception; antenatal, childbirth and post-natal care; CAC and PAC, as well as prevention and treatment of HIV and other sexually transmitted infections (Chandra-Mouli et al. 2019). The rights of adolescents to SRH services are well-documented,

although access is influenced by institutional, infrastructural, individual, and sociocultural factors (Kabiru et al. 2024). In acknowledgement of the sensitivities of adolescent health and the need for nuanced services, the Government of Kenya (GOK) rolled out youth-friendly services (YFS), which it defines as “*services that are accessible, acceptable, equitable and appropriate to meet the SRH needs of young people aged between 24 years*” (Republic of Kenya 2016: 8). In response to and alignment with international, regional and national standards on adolescent sexual reproductive health, the GOK set minimum standards for YFS through the *National Guidelines for Provision of Adolescent Youth-Friendly Services* (2015), whose objective was to increase adolescents' and young people's access to, acceptance and utilisation of high-quality sexual and reproductive health services (Republic of Kenya 2016). The guidelines are complementary to the *Kenya National Adolescent Sexual Reproductive Health Policy* (2015) that anchors its framework on human rights principles, hence, anticipating equity, provision of services with utmost dignity, care and accountability, where adolescents can provide feedback on services accessed (Engel et al. 2019).

Youth-friendly services encompass the infrastructural features of health facilities, and the delivery of health packages offered to adolescents and young people. These health packages include:

- Providing counselling and services for many contemporary contraceptives, with a specific minimum quantity and variety of methods.
- Provision of care during pregnancy, childbirth, and after childbirth, including emergency care for both the mother and newborn.
- Safe and regulated abortion services, as well as treatment for complications arising from unsafe abortion.
- Prevention and treatment of HIV and other sexually transmitted infections.
- Prevention, identification, immediate assistance, and referrals for cases of sexual and gender-based violence.

- Prevention, identification, and management of reproductive cancers, particularly, cervical cancer.
- Provision of information, counselling, and services for individuals experiencing difficulties in conceiving or infertility.
- Provision of information, counselling, and services for sexual health and overall well-being (Engel et al. 2019: 44-46).

The uptake and success of youth-friendly services are far and wide since it is predicated on individual, institutional and service-providers' factors. At the individual level, studies have shown that adolescents' inability to access SRH services is linked to personal barriers such as lack of confidence, embarrassment, fear of reprisal from health service providers and lack of information on the services available (Tamiru et al. 2024; Chimatiro et al. 2022). The lack of confidence and feelings of shame expressed by adolescents are linked to the narratives around sex and sexuality, where, depending on context, information around SRH is not shared and is generally problematised for cultural and religious reasons (Bond 2020). Other studies have indicated that adolescent girls have constrained agency when seeking health services due to adults' influence in their decision-making, for instance, parental emphasis on abstinence, whilst the service that they may need is access to contraceptives (Gillespie et al. 2022). At the same time, adolescent girls have been found to be more receptive to environments that support their capacity to make decisions, for instance, where health service providers counsel them and provide medical options (Shee et al. 2021).

Linked to the agency and capacity of adolescent girls to make independent decisions are tensions between children's autonomy, parental responsibility, and state regulation when it comes to children accessing SRH services, such as contraception and pregnancy termination (Moyo 2018). Article 5 of the United Nations Convention on the Rights of the Child (UNCRC) introduces the concept of evolving capacities of the child under the framework of parental guidance, indicating that children, at different levels, are right holders with agency to

exercise these rights, as they mature (Varadan 2019). When establishing thresholds for access to SRH services, such as access to contraception and pregnancy termination, this interpretive principle ought to be considered, but in many African contexts, this has not been the case (Warioba 2018). Coupled with this challenge is the contradictory nature of the policy frameworks around the age of consent to sex and the age of consent to SRH services. As discussed above, the age of maturity in Kenya is 18 as per the Constitution and Children Act (2022). On the other hand, the *Kenya National Adolescent Sexual Reproductive Health Policy* (2015) instructs that parental consent is required prior to dispensing of SRH services, while the *National Reproductive Health Policy* instructs that the age of consent to services is 21 years.

The access of adolescent girls to SRH services is limited by health service providers and facilities. Youth-friendly services experience limited uptake, mainly due to professional incompetency, notably behaviours and attitudes that impact negatively on young people's clinical experience (Geary et al. 2015). To further illustrate health service providers' attitudes, Gausman et al. (2021) observe that health service providers were mostly influenced by their personal beliefs, thereby, holding strong convictions on contraception and premarital sex. Other studies have demonstrated that where health service providers were offered training on values' clarification and adolescent sexual reproductive health, there were reports of improved attitudes (Gillespie et al. 2022; Ninsiima et al. 2021).

Institutional factors also influence adolescents' capacity to access and enjoy SRH services (Ahinkorah et al. 2021; Msuya 2019). To begin with, infrastructural design and operating hours of health facilities have been determined to have an impact on the effectiveness of YFS, with young people preferring locations with easy access and with an acceptable level of privacy (Jacobs et al. 2023). Equally, a study carried out in Kenya, with health service providers, noted that their facilities were not equipped to support youth-friendly services, given the lack of physical facilities and support from management (van Oirschot et al. 2023). Similarly, a study conducted among young people in Zambian institutions of

higher learning, indicated that the students failed to access appropriate services due to the unavailability of medical supplies and equipment (Jacobs et al. 2023).

Adolescents' access to SRH services is influenced by economic factors (Awuah et al. 2024). The cost of healthcare is a critical factor in adolescent girls' access to SRH services; hence, financial resources are crucial to the implementation of the existing policies and legal frameworks on sexual reproductive health (Mutea et al. 2019). The WHO estimates that the cost of meeting a woman's maternal health and contraception needs is \$9 per capita annually, but low- and middle-income countries remain underfunded, although health financing is critical to the attainment of SRH rights (Kieny & Evans 2013). The WHO's Commission on Macroeconomics and Health recommends that governments invest \$34 per person, yet lower middle-income countries (LMIC) are unable to do this. In 2009/10, Kenya spent \$12.20 per person, an equivalent of 5.4% of the total GDP, showcasing a deficit in domestic resourcing (Kibira et al. 2021). Low expenditure on health in LMIC has necessitated the accessing of finances through external funding via aid mechanisms mobilised through donors and civil society organisations (Hoehn et al. 2015). Globally, the Official Development Assistance (ODA) to sexual reproductive health has been found to be inconsistent; notably, there was an increase in 2009 and 2013 to \$9.3B and \$10.9B, respectively, and \$11.1B in 2017. This dipped to \$7.9B in 2019 due to the US withdrawal of funding (Kibira 2021).

In Africa, medical services are accessed either through private and public health providers, therefore, financed through government health insurance, private insurance or paid out of pocket (Lince-Deroche et al. 2019). Financing for healthcare in general and for adolescent girls in particular, can be analysed within the context of universal health coverage (UHC), which the World Health Organisation defines as "*a state where all people can access quality health services, they need without experiencing financial hardship*" (Hagos et al. 2023: 2). Investments in health service delivery systems, personnel, infrastructure, communication systems, health technologies, information systems, quality

assurance methods, governance, and laws are all necessary to achieve the right to health (Kagwe et al. 2023). African governments have demonstrated political goodwill towards the UHC; however, challenges abound, and this has a direct implication on the affordability and accessibility of adolescents' access to SRH services (Oraro-Lawrence & Wyss 2020).

Research has found that SRH discussions are excluded from UHC discussions at national and global levels, especially where resource mobilisation and allocation as well as priority setting are concerned (Ravindran & Govender 2020). SRH services, such as maternal health and family planning are covered as a health benefit package, leaving out services such as abortion, comprehensive sexuality education and cancer screening (Kangaude et al. 2020; Ravindran & Govender 2020). As of 2023, Kenya had not met the Abuja Declaration commitment of allocating 15% of its domestic budget to health, highlighting the need to accelerate domestic resource mobilisation initiatives to achieve universal health coverage. In most African countries, government expenditure on health was less than 50%, thus, over 50% of health expenditure is paid out of pocket, donor aid, and the private sector (African Institute for Development Policy 2023).

Over the years, the investments of the Kenyan government towards SRH services have included free maternity services (FMS). This was introduced in 2013 through a presidential directive towards achieving UHC, resulting in the elimination of user fees, with an aim of increasing access to skilled maternal healthcare, in all public health facilities (Gitobu et al. 2018). This move was lauded for increasing access to ANC attendance and facility delivery through normal and caesarean births, although it only responded to economic barriers, leaving out health system barriers, including the shortage of healthcare workers who are pertinent to the access of maternal healthcare (Lang'at et al. 2019; Gitobu et al. 2018). Other government-led interventions relevant to accessing SRH services for adolescents, include health insurance schemes, such as the National Health Insurance Fund (NHIF), which was the largest insurance service provider offering free services to more than 80% of Kenyans (Mbau et al. 2020).

All Kenyans, both in the formal and informal sectors, as well as their spouses and children under the age of 18, were covered by the NHIF. Under this scheme, the government managed a pooled fund where monthly deductions were made from paid members and voluntary contributions were made by non-salaried Kenyans (Were et al. 2020). The NHIF initiatives included the Health Insurance Subsidy for the Poor (HISP), which aimed to provide free comprehensive health insurance coverage to 9 million poor Kenyans by 2020; the *Inua Jamii* programme, which intended to offer free comprehensive health insurance coverage to the elderly and persons living with physical disabilities; and the *Linda Mama* programme, offering free maternity services to all adult and adolescent Kenyan women (Oraro-Lawrence & Wyss 2020).

The *Linda Mama* programme is relevant to the needs of pregnant adolescents, as it offers an expanded package on maternity, including ante-natal care (ANC), post-natal care (PNC), deliveries and management of complications for the mother and child (Murira 2020). Pregnant women are registered under the programme, through their identity cards, spouse's identity cards or guardians' identity cards in the case of adolescents, by community health workers. This is done via a mobile phone at the facility level during ANC visits at clinics (Ochieng et al. 2022). The impact of this initiative is perceived as positive; for instance, the impact on pregnant women's health-seeking behaviours, such as increased attendance of ANCs and use of skilled birth attendants, as opposed to traditional birth attendants (Ochieng et al. 2022).

There is clear evidence of expanded services provided under the programme, despite this, there are limitations noted. Studies have found that not all services are offered to women, contrary to the implementation guide; for instance, post-abortion care, family planning, outpatient care for the mother and logistical support in case of emergency referrals are not offered (Orangi et al. 2021). The *Linda Mama* programme does not cover critical cost drivers that catalyse access to health, such as the cost of travel and food (Mutai & Otieno 2021). In some cases, at the point of registration, patients are required to photocopy their identity

cards (ID) or register via a mobile phone, all of which have a cost implication, while some guardians do not have ID cards, further disadvantaging adolescent girls. Slow reimbursements to the facilities via the county government are slowly making it difficult for facilities to stock medications. In addition, low awareness of the initiatives among the clients compared to service providers, including low awareness of the service package, points to a gap regarding communication (Murira 2020).

In 2023, the government of Kenya passed the Social Health Insurance Act (2023), which introduced the Social Health Insurance Fund (SHIF), replacing the NHIF (Dika 2024). Unlike the *Linda Mama* programme under NHIF, where pregnant adolescents could register for services using their parents' IDs, SHIF intends to use a 17-step assessment approach to determine mothering adolescents' annual premiums based on their income and assets. This approach could prove disadvantageous to adolescent girls who, for the most part, are dependent on parents and spouses with limited income or financial resources (Obudho & Ngure 2025).

The relationship between UHC as an enabler of adolescent SRH should be reviewed from the following perspectives. Firstly, who within the adolescent girls' population is targeted or can receive financial support. Secondly, the type of services they can receive as per SRH policies in the country, and finally, affordability, as evidenced in the cost of those services sought. To buttress this, Ricker & Ashmore (2020) maintain that service provision alone is not enough for adolescent girls, underscoring the imperative of a feminist-agency-centred approach to UHC where multiple and intersecting vulnerabilities that adolescent girls face are integrated into the ongoing debates and actions on health financing for relevance and sustainability.

### **2.3.4 Regression in and backlash against SRHR**

The discourse around sexual and reproductive health is influenced by religious ideology, political power, and male hegemony, and these polarities influence CSOs' roles in advancing sexual reproductive health and rights (Akwara & Idele 2020). To begin with, African countries are highly religious, and SRH values of bodily autonomy and gender equality are viewed as anti-family and a disruption to God's order (McEwen 2021). American Christian rightists have played on these religious extremities to fund SRHR opposition in policy spaces as well as within Christian congregations (Kaoma 2023; Opondo et al. 2024). Organised religion, specifically the Catholic Church, was at the centre of post-colonial nation building in most parts of the world (Calkin & Kaminska 2020). As a result, they were pivotal in advancing gender ideology as a way of gatekeeping and restoring heteropatriarchal social order (Paternotte & Kuhar 2016).

According to African feminists, this resistance to SRH rights is tied to coloniality. Moreso the shaming of African female bodies, therefore, opposition to sexual reproductive health rights is a continuation of colonial legacies to enforce western patriarchal norms (Tamale 2011). Therefore, an agitation for adolescent SRH rights is an act of decolonisation that challenges the state's use of culture and tradition to police adolescent girls' agency and bodily autonomy. In Kenya, religious organisations more so, the Catholic Church has a strong foundation in post-colonial nation building through the provision of essential services such as health and education. They operate 31% of the country's learning institutions, and this gives them moral legitimacy with their congregants and populace (Omunyin 2026). The Catholic Church's influence is sustained through a dedicated followership that views the Church's SRH ideologies as a core component of their spiritual lives and national identity (Bunguswa, Wepukhulu & Matisi 2025).

Additionally, the Catholic Church's capacity to censure SRHR is based on their access to political and legislative bodies and ability to mobilise their masses to advance political causes (Calkin & Kaminska 2020). At the same time, American evangelicals are deeply involved in pro-life advocacy in the African continent, promoting family values and castigating SRH rights, including abortion, contraception and rights of sexual minorities (Mcewen 2023). These religious formations infringe on women's agency, bodily autonomy and dignity with no regard for their needs and vulnerabilities (Pugh 2019). These right-wing Christians deploy propaganda, anti-Western influenced dogma and charismatic messages around culture to influence policies and practice around SRH. Kaoma (2012) opines that these opposition groups have gained ground based on neocolonial privileges as they leverage their financial muscle and strong global-political influence, which appease their audiences.

African feminist critique notes that the oppositions financial muscle is used as leverage and local politicians and CSOs are coerced into adopting regressive agendas to maintain access to foreign capital (Tamale 2020). Likewise, political mobilisation against SRHR is well organised, with players operating within strategic spaces at national and global levels, including the UN (Cupać & Ebetürk 2020; Dandan & Yiping 2015). African feminists view the commingled character of Church and State as a betrayal of the postcolonial promise; rather than liberating the African body, the state serves as a surrogate for patriarchal domination (Tamale 2011). Church and state are interwoven within policy circles, where right-wing Christians have built out legal formations to influence policy and legislative processes, including constitutional review processes in countries like Kenya (Kaoma 2012 & 2016). Previously, the Washington DC-based American Centre for Law and Justice set up offices in Uganda, Kenya and Zimbabwe with the aim of lobbying African parliaments to integrate Christian values in law-making sessions (Kaoma 2012).

Most recently, backlash against SRHR ignited anew, under Donald Trump's presidency as he reinstated the Mexico City Policy, also known as the "global gag

rule”, which Republican presidents have implemented since 1984 (Ahmed 2020). Under the global gag rule, the United States, the biggest global health funder, prevented NGOs from receiving health assistance if they were in any way engaged with abortion-related issues. The rule has had far-reaching implications; for instance, major SRH organisations such as UNFPA and IPPF witnessed budget cuts which had an impact on the provision of services and continued high-level advocacy (E-Murshid & Haque 2020). In Kenya, the global gag rule reaffirmed the pre-existing anti-SRHR discourse and fractured CSO networks into two camps: those who signed and those who resisted it (Ushie et al. 2020). From an African feminists’ perspective this splitting of SRHR movements into binaries was a purposeful violation of sisterhood and collective agency. Skuster, Khanal & Nyamato (2020) contends that the global gag rule is a tactic of imperialist biopower in which the US government controls who lives and who dies in the Global South by limiting life-saving knowledge.

The global gag rule also silenced practitioners’ voices: for instance, health practitioners and advocates could not raise their voice on all matters related to abortion. In so doing, anti-gender and anti-rights advocates amplified their voices against sexual reproductive health and rights (Lane et al. 2021). Under the Trump presidency, even the UN came under attack from anti-feminist lobbyists led by religious groups, conservative NGOs, and some African and Arab countries (Cupać & Ebetürk 2020). This was evidenced in the development of UN Resolution 2467 of the Women, Peace and Security agenda, where the Trump administration argued that the use of the agreed-upon SRH language was akin to abortion and threatened a US-led veto if the framing was not changed (Cupać & Ebetürk 2020). This has resulted in the agreed language on SRHR post-ICPD gradually missing in key UN documents and resolutions; for instance, Gilby et al. (2021) found that words, such as “abortion” and “comprehensive sexuality” have respectively disappeared from CSW documents since 2017 and 2018. These SRHR language framings are being replaced by conservative lingua, such as “family focus” and “values”, which water down the essence and gains from ICPD.

In November 2024, Americans went to the polls and re-elected Donald Trump for a 4-year term. Upon his inauguration in January 2025, he signed off executive orders that are detrimental to gender equality and women's rights. The Trump administration, for example, initiated a US withdrawal from the WHO, where it was the largest contributor to the tune of \$1.3 billion between 2022 and 2023 (Focus 2030 [2025]). At the same time, Stop Work Orders (SWO) were issued where President Trump mandated a 90-day pause of US aid assistance to evaluate its alignment with American interests. Resultantly, 83% of aid was cut and only humanitarian and lifesaving projects were reinstated excluding activities linked to family planning. Among the projects discontinued were those related to HIV/AIDS, gender equality and women's rights as well as Diversity, Equity and Inclusion (DEI) (Focus2030 [2025]).

As is expected of a Republican presidency, the Mexico City Policy will be reinstated, which in the past saw UNFPA's funding cut by \$70 million. These changes will disrupt SRH programming globally, including efforts to undermine SRH programme interventions through global platforms, such as the UN, which may include the US rejoining the Geneva Consensus Declaration on Promoting Women's Health and strengthening the family (Focus 2030 [2025]).

Upon the reinstatement of the Mexico City Policy, the Government of the Netherlands rose as a champion for gender equality, which included bankrolling the She Decides campaign to the tune of 260 million Euros (She Decides 2018). This commitment rapidly shifted in January 2025 when the rightist and conservative government was voted in, as evidenced in the Foreign Trade and Development Assistance Policy Paper with a similar capitalist rhetoric of 'Netherlands first' with an emphasis on developing Dutch entrepreneurs (Government of Netherlands 2025).

This subsection has demonstrated that adolescent sexual reproductive rights are well articulated in global, regional and national normative frameworks yet their full implementation is inadequate. The literature reviewed indicate that SRH

outcomes for adolescent girls are profoundly curtailed protectionist standards, ideological divergence (protectionist vs. justice), underfunded health systems, donor imposition, gendered norms, geopolitics and religious dogma. African feminist thought asserts that these dynamics are rooted in the coloniality of gender, which views the African adolescent girl as a site of labour and reproduction rather than a human being with full sovereignty (Tamale 2020). These dynamics render adolescents' girls simultaneously as policy subjects and marginalised rights holders underscoring the limitations of rights-based frameworks that fail to address power, agency and inequality. It is with this background that the reproductive justice theory offers a relevant analytical lens for an integrated analysis of structural issues that interplay and shape adolescent girls' reproductive experiences. The next subsection situates the role of CSOs in the advancement of adolescent sexual reproductive health, more so in engaging with adolescent pregnancy as a social, political and a human rights issue.

## **2.4 INSTITUTIONALISED ACTIVISM: CIVIL SOCIETY ORGANISATIONS ROLE IN REPRODUCTIVE HEALTH**

### **2.4.1 Theory and evolution of civil society**

The concept of civil society has undergone construction, deconstruction, and reconstruction in numerous ways, resulting in its fluidity as well as its varied theoretical pedigree and disciplinary conventions (Pointer et al. 2016). Classical thinkers like Plato and Aristotle contended that human beings are intrinsically cogent with the ability to voluntarily deliver on their social functions for the common good in a peaceful manner. To them, a civilised society was one of order and duty as well as engagement in political processes, free of violent actions (Kelkil 2015). The concept of civil society shifted in the Middle Ages in Europe with a rise in feudal political systems and monarchies, which introduced state power over citizens and an introduction of class, taxation and armies, all of which were geared at controlling citizens and the economy (Van Dijck 2017). With this,

civil society, as envisaged by the classical thinkers, could not hold, as there were tensions between individuals, communities and the state (Kelkil 2015).

The concept of civil society shifted during the Age of Enlightenment, during which religion was used to legitimise absolutist tendencies. Political and religious systems were deemed to be hindrances to strong civil society as they collectively infringed on people's rights and freedoms (Fine 1997). To this end, Starr, Martínez-Torres and Rosset (2011) described civil society as - a state or condition that exists when people are ruled by law; when freedom of speech and association prevails; when a multitude of voluntary groups work freely to foster civic ends, and when the people consider themselves to be citizens rather than subjects. The philosopher Jean-Jacques Rousseau moved away from the focus on individual rights and happiness within social contexts that were unregulated, warning that unequal power relations would advantage the rich (Kastrati 2016). Rousseau offered that the pursuit of common good and shared civic values through social contracts would promote the wellbeing of communities; in this case, the state would lay out the parameters for the common good (Kastrati 2016).

The modernisation era further shaped the concept of civil society, where the philosopher Hegel framed it as a place of self-organising and solidarity to voluntarily promote greater good (Musinguzi 2019). Hegel perceived the state as having a role in recognising and facilitating the rights of its people and suggested that the fulfilment of personal wants, preservation of personal property and broader human needs defined civil society, thereby, charging the state with the mandate of ensuring that different interests intersected (Avineri 1972). By contrast, Marx's writings on civil society challenged Hegel's perspective on the state's role in civil society relations, arguing that the state was a partisan entity representing the interests of the dominant class and other political interests, thus failing the neutrality test (Laine 2014). Gramscian hegemony posits that civil society is a space for voluntary engagement promoting democratic ideas and defending people's interests against the state. He was a proponent of separating

the state and civil society, noting that the state was obligated to support civil society's very existence (Kastrati 2016). Gramsci underscored that democratisation and development in the Global North flourished because of a present and active civil society (Hoare & Smith 1971). Gramsci's work contributed to the conceptualisation of civil society, elevating it from a conduit of social norms to a platform for movement-building based on shared identities and values (Laine 2014).

#### **2.4.2 Civil society organisations in a neoliberal world order**

The foregoing conceptualisations lay out a frame for understanding the evolution of civil society as a concept, space and institutions. Common factors emerging from the diverse framings of civil society, include a recognition of acts of voluntarism, freedom of association, active citizenry checking on the excesses of those in power and a separation of family, the public and the state. Civil society is nevertheless conceptually complex because it incorporates ideologies from several historical eras, geopolitical circumstances unique to Europe, and changing contextual experiences (Aksan 2019). The notion of civil society and the operationalisation of civil society organisations are not always analogous, especially when neoliberal conceptions of civil society take an upper hand (Kutay 2024). Over time, neoliberalism orchestrated a move away from the state as the fundamental driver of development and placed an emphasis on individuals rather than social solidarity, hence, the preference for CSOs as a development actor became more apparent in the 1970s (Baru & Mohan 2018).

#### **2.4.3 Institutionalised activism: navigating the tensions of managerialism, professional dogma and social justice**

As civil society transitioned into the neoliberal world order, the original conception of a fluid space for voluntarism, self-organisation, and active citizenship has become increasingly formalised (Peck 2019). This shift has led to the

professionalisation of civil society, where organisations are governed by rigid administrative structures and professional dogma that mirror the very state bureaucracies they seek to challenge. Consequently, a persistent tension emerges between the visionary pursuit of social justice and the pragmatic requirements of day-to-day operations. In the context of adolescent SRH, civil society organisations operate under the auspices of Human Rights-based Approaches (HRBA) (Tucker et al. 2019). This paradigm reconceptualises poverty through individual and structural lenses, examining the implications of politics, sociocultural issues and their impact on people's freedoms and capabilities (Sempere 2016).

A human rights-based approach seeks to disrupt power structures and devolve decision-making to rights-holders (Sida 2022). CSOs play a significant role in promoting and protecting human rights for all by engaging in policy discourses, setting up monitoring mechanisms and working with communities to organise and claim their rights (Khosla et al. 2020). Furthermore, CSOs occupy strategic spaces at policy-making levels that could be used to advance women's rights issues, particularly sexual reproductive health and rights. CSOs, for instance, were instrumental in advancing the SRH agenda pre- and post-ICPD and they have the mandate to monitor its implementation (Brown et al. 2019; Garita 2014). While CSOs strive to remain rooted in their transformative principles, they must simultaneously navigate the technical demands of institutional survival, resulting in a complex landscape where activism is often mediated through professionalised frameworks.

The operations of civil society organisations is linked to internal and external factors such as organisational mission and programming strategies, geographic footprint, donor priorities, evolution of global challenges, community needs and government regulations (Bano 2019). Given the multiple roles that they play on the development continuum, CSOs fit into a cluster of multi-identity organisations, which Heckert et al. (2020) describe as institutions that hold characteristics that can be attributed to diverse and potentially conflicting values. In the context of

sexual reproductive health and rights, some CSOs engage as service providers in contexts where government services are inadequate (Munyuzangabo et al. 2020; Singh et al. 2018). CSOs are funded and regulated by the private sector and government; this creates a significant clash more so on the separation with state and market (Obadare & Krawczyk 2022). This tension is evident and articulated in the *Kenya National Adolescent Sexual and Reproductive Health Policy (2015)* which explicitly mandates non-state actors to support the provision of SRH information and services (Republic of Kenya 2015). To navigate this, Prata and Summer (2015) highlight that CSOs must possess strong political leadership and an appreciation of political windows to ensure they remain emboldened enough to check the excesses of powerholders while fulfilling their service delivery roles.

#### **2.4.3.1 Managerialism and social justice**

Despite their justice orientations, CSOs work under the logics of managerialism, which is described as the optimisation of productivity and outcomes through the application of managerial expertise, theories and techniques (Doran 2016). Managerialism advances the professionalisation of roles and processes in CSOs, highlighting efficiency and results. Capacities required of a well-functioning CSO, therefore, include governance, project management, financial and grant management, communications, monitoring and evaluation, human resource management and fundraising (Kumi et al. 2021; Kamstra 2020). Critics warn that managerialism results in a deviation from CSOs' core mandates as they are paralysed by the dogmatic regulations set out by donors and regulatory authorities (Girei 2023; Doran 2016).

The broad mandate that CSOs hold in advancing SRH, requires that they have the capacity to deliver on the different components of their work. For example, the *Kenya National Adolescent Sexual and Reproductive Health Policy (2015)* states that non-state actors will support provision of SRH information and services to adolescents and communities (Republic of Kenya 2015). In this case,

it is expected that the capacity of CSOs is aligned to the World Health Organisation's core competencies for SRH in primary health care that include - ethics and principles towards a client's human rights; leadership and management of health facilities; working with and in communities; counselling and assessments (and referrals as needed) as well as specialised clinical competencies (Rehnström et al. 2023). A reproductive justice lens posits that the technocratization of SRH issues and the expectation that CSOs possess technical competencies for their diverse mandates, increases administrative and managerial burdens to the CSOs.

Similarly, sexual reproductive health of adolescents is a women's rights issue, therefore, a CSO implementing adolescent SRH programme interventions require an appreciation of rights-based perspectives and a capacity to advocate for the rights of women. To illustrate this, Chaney (2016) introduced the concept of Substantive Representation of Women (SRW), which he described as a situation whereby women's needs and concerns are reflected in public policy and politics. He outlined that factors that influence CSOs' advancement in SRW are political, socioeconomic, and organisational in nature. These included the extent to which the government embraces gender equality, governance structures that linked the state and civil society, availability of resources for policy reforms and appropriate attitudes around gender relations (Chaney 2016). In effect, the government provides an enabling policy and political environment for CSOs to deliver on their SRH mandate. Finally, civil society organisations require competencies in research, budget advocacy and political economy analysis, to enable their policy, legislation and resource mobilisation roles (Mangwana et al. 2023).

A significant setback to the purpose of civil society organisations is the process referred to as "NGO-isation" by Lang (2022), which is defined as a process by which social movements professionalise, institutionalise and bureaucratise in vertically structured, policy outcome-orientated organisations that focus on generating issue-specific and, to some degree, marketable expert and advice

(Lang 2022). Specific to sexual reproductive health and rights, *NGOisation* in feminist movements can be traced to the 1975 UN World Conference on Women in Mexico, where a key outcome of women's activists' demands for the advancement of gender equality was the setting up of agencies within state functionalities. This was attractive to networks of feminist organisers, as they needed to be formal, legitimate, and professional in engaging in mainstream women's rights politics (Ana 2023). Implicitly, civil society organisations integrated into the formal policy-making systems, collaborated with government to curate technical solutions to gender-equality issues in a non-politicised and non-aligned arena. As a result, civil society organisations fell short of building their constituencies, increasing accountability horizontally to government and donors, and depoliticising their work (Chakraborty 2021).

Another impact of neoliberalism in civil society work was the uptake of *NGOised* culture, which ascribed to the commodification of processes and the rise of organisational formations that were competency-based, with less focus on values. Professionalisation of civil society organisations moved towards corporate culture with a focus on quantified results and programming outcomes as well as opening of funding sources which had rules and regulations to be adhered to (Arda & Banerjee 2021). Increasingly, a civil society organisation's capacity to access funding was linked to how professionalised they were, thereby incentivising them into professionalisation.

#### **2.4.3.2 Transnational partnerships and politics of localisation**

The transnational nature of social change amplifies these managerial tensions. Partnerships between Global North and South CSOs are often contested due to unequal power relations and the North's control over agency and funding (Fowler 2016). According to Katisi et al. (2016) donor-partner relations and North-South disparities continue to contest approaches to partnerships due to unequal power relations. Traditionally, global CSOs have held power and control over their local counterparts given their proximity to donor governments and other sources of

funding (Crawford & Andreassen 2015). In the past, CSOs with origins in the global north have administered close to \$50 billion per year through government funding, and approximately 40% of their budgets are government-funded (Ofstad 2017). Partnerships between CSOs in the Global North and South have been run via sub-granting arrangements where CSOs in the South are presumed to have more interaction with communities hence a stronger constituency, with stronger political and social capital and a sound appreciation of the context (Ngumbela & Mle 2019).

Colonial perspectives around CSOs in the Global South, however, propagate narratives around lack of capacity and accountability while relegating the influence of geopolitics, neoliberalism, and racism within the aid architecture (Aloudat & Khan 2022). To illustrate this, CSOs in the Global North are framed as having efficient systems required to manage donor requirements stronger technical capabilities to deploy this mandate, and access to advocacy and campaigning spaces (Ferati et al. 2023). To address matters arising from these unequal power relationships in the broader aid architecture, different mechanisms have been set up to guide processes of change. An infamous example is the Grand Bargain, which was signed off by aid donors and providers at the World Humanitarian Summit 2016 (Eyokia & Croome 2023). Commitments were made towards localisation, where local and national actors would have access to increased financial resources and the recognition that local and national actors are first responders and more knowledgeable about their contexts; hence, a push for localising programmatic interventions (Mulder 2023).

Over the years, the localisation agenda has faced criticism from a range of actors. To begin with, there has been a disproportionate focus on downward financial flows and management towards 'local and national' CSOs. This has resulted in increased financial and administrative processes to manage financial risk directly transferred to the local and national' CSOs by the relevant donors (Goodwin & Ager 2021). Additionally, the increased emphasis on CSOs with 'strong' financial management capabilities has resulted in competition among CSOs, as the 'few'

with 'strong' capacity attract more interest and funding from international CSOs (Koch & Rooden 2024). At the macro-level, the localisation agenda fails to address the hitches within the global aid structure that perpetuate colonial politics and policies. Nationalism, for instance, plays a central role in the distribution of aid; therefore, donor countries align their contributions to ODA, to their national interests (Scott 2022). At the micro level, critics have found that racism plays a role in unequal power relations between global aid donors and 'local and national' CSOs, compared to how the same donors engage, global CSOs (Scott 2022).

#### **2.4.4 Civil society organisations as third sector actors: a critical perspective**

Traditionally, civil society organisations have been viewed as important catalysts for social change. Over time feminist and critical development scholars have increasingly scrutinised this hypothesis, questioning their neutrality and transformative claims (Karioris 2021). A significant critique of CSOs relates to their role as shadow state actors, whom Wolch (1990) identified as organisations that take over the role of government responsibilities especially service delivery during post-structural adjustment programmes. To Wolch, CSOs operating in this dispensation ended up dependent on government for financial resources, losing independence and failed to deliver on their advocacy mandate. Wolch's perspective resonates with Gesesew et al. (2025), whose study found that civil society organisations play different roles in health, including providing service to fill in government gaps.

Studies have demonstrated that CSOs in the Global South sustain rather than challenge neoliberal ideologies as a survival strategy and sometimes passively involve themselves as a player in the global aid ecosystem. Hearn and Lavers (2022) point out that CSOs in East Africa are increasingly institutionally involved in neoliberal restructuring by integrating and depoliticising societal demands that may otherwise exert systemic pressure on states. Similarly, Mama (2007; 2011; 2020) maintains that CSOs are a product of a neoliberal centred post-colonial civil society architecture that is influenced and driven by donor regulations and

results-based service delivery. It is commonplace for CSOs addressing adolescent sexual reproductive health issues including adolescent pregnancy in Kenya to subsidise dysfunctional health system thereby normalizing the absence of state intervention rather than advocating for state accountability (Khisra 2021; Tudela 2025; Tvedt 2023).

While there is a presumption of impartiality on the part of CSOs, others, like Choudry and Kapoor (2023), contend that they promote organisational interests, much to the detriment of the constituencies they serve. As a result, they marginalise grassroots and community-based entities more, so where financial resource allocation is concerned. This systemic imbalance within civil society triggers critical questions regarding whose perspectives are prioritised in the formulation and execution of social justice initiatives and whose interests ultimately influence the agenda.

Feminist scholars caution that gender-focused and development organisations despite their progressive goals, are likely to advance paternalistic and colonial practices. Arhin-Sam & Obeng-Odoom (2022) note that African gender and health CSOs are epistemically confined to Northern feminist frameworks, thereby obscuring culturally specific experiences of reproductive autonomy present in African communities. The tensions between reproductive justice a foreign based paradigm, and the African centred epistemology are discussed under section 2.5.

#### **2.4.5 Challenges facing CSO operations**

Civil society organisations face a myriad of challenges in deploying their mandates. Firstly, their work is regulated by government policies and legislative frameworks to which they must abide. States have used legal frameworks to silence civil society organisations, especially those that are vocal on human rights and governance issues, for instance, Ethiopia and Kenya (Glasius et al. 2020). Governmentality is displayed in regulations on funding and advocacy work, as well as accountability to government bodies, like the NGO Board in Kenya, which

has the power to register and deregister CSOs (Glasius et al. 2020). Secondly, CSOs are subject to statutory and administrative processes for the purposes of compliance and legitimacy, at least with the state. The administrative requirements from the state play a role in shaping CSOs operating models; for instance, organisations must spend resources employing professionals, such as certified accountants who oversee compliance, in effect, intensifying managerialism (Heylen et al. 2020).

This increased focus on professionalising processes contributes to mission “creep” in the sense that CSOs become more focused on accountability to donors and regulators as opposed to their core mission and constituencies (Lang 2022). Thirdly, donor influence and demands continue to shape CSO identity and engagements; for instance, CSOs face pressure to demonstrate the impact of their work, yet development challenges such as SRH are deeply rooted in culture and neocolonial systems and take time to change (Abiodun et al. 2024; Banks 2015; Peck 2019). Donor’s imposition of rules and standards to CSOs is attributed to their public’s scepticism about aid and increased demand for results, however, these prerequisites fail to understand the complexities of development both as a process and as an outcome (Kloster 2020; Storeng et al. 2019).

The relevance of CSOs continues to be contested. Hilton (2018) asserts that organisations like Oxfam, Save the Children Fund and Christian Aid rapidly expanded over time, changing the humanitarian sector, with no agreement on what their role in poverty alleviation would be. He further contends that CSOs are everything to everyone based on their interest, arguing that the academy has not interrogated the impromptu, vague, and multifaceted role. Historically, these organisations had a role in representation, especially in democratisation processes, but increasingly shifted towards representing the plight of the poor and most vulnerable in the context of economic liberalisation (Ofstad 2017). As a collective, CSOs are criticised for being detached from their constituents and their inability to genuinely present the political interests of their constituents, relative to other actors in the development space, like social movements (Samutereko

2024). This perspective differs from that of transnational theorists, who perceive shared values and norms as greater than actual organisations. To them, motivation does not emanate from economic interests but rather the values that they share with others across the globe, and their value proposition comes from their expertise and morals, and this is what gives them political legitimacy (Ofstad 2017).

The foregoing subsections have demonstrated that CSOs that advance social justice agenda are integrated into, and influenced by, the power systems they seek challenge. Even though CSOs deploy themselves in service delivery and advocacy, their mandate is heavily influenced by donor influences, regulatory procedures and internal power hierarchies. These polarities affirm that CSOs contribution to adolescent girls' reproductive autonomy in the context of adolescent pregnancy cannot be isolated from the political economy within which they operate.

Based on the previous subsection on the barriers to ASRH realisation, the forthcoming section discusses CSOs engagement with family planning, an area of work that is core to SRH in general and adolescent girls' sexual reproductive health in particular.

#### **2.4.6 Civil society organisations and family planning**

The engagement of civil society organisations in sexual reproductive health can be situated in the context of family planning and global development, which transitioned from population control to the promotion of safe motherhood and rights-based family planning programming (Goodkind et al. 2018). Family planning programming refers to a combination of activities that promote low fertility and encompasses the development of policy frameworks, the provision of services and information, and accessibility of commodities (Starbird et al. 2016). Family planning is a scientific and political concept; from a scientific perspective, family planning is concerned about - who can get pregnant, when they can get

pregnant and the frequency at which they can get pregnant. On the other hand, the politics of family planning entail - decision-making on accessing contraception (whether a woman can get their preferred choice of contraception), how governments prioritise access to contraception as a basic right to health and the stakeholders involved in the supply of contraception (Potvin 2024). Both perspectives are critical to the realisation of adolescent reproductive health rights and the role of civil society organisations in advancing the needs and interests of their constituents.

The objectives of family planning in global development have morphed over time. Historically, family planning was anchored on two distinct philosophies. On the one hand, feminism, where the likes of Margaret Sanger pushed for access to birth control for all women as a way of emancipating them. To her, contraception, especially the pill, gave women the freedom to choose the number of children they would have, allowing them a chance to engage in other facets of life (Robinson & Ross 2007). The more dominant philosophy was derived from Malthus who was concerned about population growth against a country's capacity to respond to its rapidly expanding needs, especially among the poor in Europe (Hodgson 2016). The Malthusian philosophy presented population control as a necessary mechanism for addressing socioeconomic, political and environmental issues, particularly poverty reduction, maternal mortality and women's empowerment (Ibrahim 2022). The Malthusian philosophy gained most popularity and had since been integrated into many disciplines, forming a basis for global policies, including the SDGs and national family planning programmes (Starbird et al. 2016).

Family planning programmes became popular in the 1960s, gaining backing from proponents such as the US government, whose impetus was to balance population control with economic development (Robinson & Ross 2007). The political goodwill demonstrated by the American government translated into technical and financial assistance, resulting in many countries onboarding voluntary family planning programmes between 1974 and 1994. With regards to

family planning actors, the US government and the World Bank financed the rollout of family planning programmes at the onset through financial aid and loans to countries in the developing world; this included setting up the United Nations Population Fund (UNFPA). Additional financial support was advanced by institutions such as the Ford, Hewlett, Gates, MacArthur, and Rockefeller Foundations (Robinson & Ross 2007).

The global family planning governance structure shifted in 1984 when the Reagan administration shifted its focus from supporting family planning interventions due to abortion-related issues. This carried on for 12 years under the embargo of the Mexico City Policy. The absence of financial and political leadership on matters related to family planning after the Reagan Administration opened new leaders in the family planning ecosystem at the global level, such as BMGF (Fulpagare et al. 2019). Today, BMGF is a global leader in family planning, having invested over \$2 billion in grants through bilateral and multilateral mechanisms towards initiatives such as, FP 2030, medical research, and provision of family planning commodities (Howerton 2021).

Civil society organisations are key actors in the family planning sphere at the global and local levels. For instance, organisations like IPPF have furthered the family planning agenda since its inception in the 1950s (Claeys 2010). The IPPF was established with initial investment from the Rockefeller Foundation and later from corporates including Dupont Chemicals (Wilson 2018). Another civil society player in the family planning agenda in the 1950s was the Population Council, founded by John D. Rockefeller III and focused on medical research, training, and facilitating conversations and platforms that brought different stakeholders together towards progressing a population management agenda (Seltzer 2002).

In recognising that family planning narratives and practices included degrading acts such as eugenics and sterilisation, feminist civil society organisations and social movements worked towards advocating for the adoption of human rights principles in the provision of services and adoption of legislation (Nandagiri 2021).

Specifically, these movements demanded a shift in language, the setting of realistic global targets, ensuring availability of family planning commodities and an increasing focus on voluntarism and women's agency. As a result, shifts from population control towards holistic sexual reproductive health rights, came to the fore during the ICPD 1994. This included an increased focus on reproductive justice as a framework that moved beyond women's choice, thereby, essentialising the role of intersectionality and social justice on matters of sexual and reproductive health.

Civil society organisations continue to play a role in influencing countries' adoption of policies and programmes on family planning (Roberts 2009). To illustrate this, the Ethiopian Society of Gynaecologists and Obstetricians and its partners undertook research that informed the population policy's development, which included the legal framework and associated health policies (Holcombe 2018). The Ethiopian Women Lawyers' Association was at the forefront of advocating for and creating awareness around the need for legal reform (Prata & Summer 2015). Over the years, the family planning agenda has been implemented through national programmes which have been in mainstream development assistance discourse for demographic, health and human rights reasons. India developed its first family planning programme in 1952, and in the 1970s, the UN set up a mechanism for monitoring uptake of family planning programmes. African countries bought into the family planning agenda from a health standpoint and later from a population control viewpoint, as the latter began to expand (Seltzer 2002). Kenya was the first country in sub-Saharan Africa to adopt a national family planning programme in the 1960s, although family planning services were available in Kenya as early as the 50s, even though it was the preserve of Asians and Europeans (Heisel 2007). In 1962, the Family Planning Association of Kenya (FPAK) was established with an affiliation to IPPF, whose Africa Region counterpart was set up in 1971. Among IPPF Africa's major contributions was the push towards the adoption of the Maputo Plan of Action (Claeys 2010).

In 1965, a Sessional Paper No. 10, *African Socialism and its Application to Planning in Kenya*, issued a call for regulation of population growth in Kenya, establishing a policy basis for a national family planning programme (Government of Kenya 1965). Consequently, in 1971, the government of Kenya formally called for the World Bank's support for the establishment of a national family planning programme. In 1975, funding of \$39M was made available towards the expansion of a national family planning programme which was to cover the set-up of the national family welfare centre, community nursing schools and the building of 30 rural health centres (Crichton 2008).

#### **2.4.7 Critiques around family planning programming and development**

The family planning ecosystem is marred with criticisms ranging from the principles that underpin interventions or services, to motivations of the actors in global health governance and the impact of a broader agenda (Senderowicz & Valley 2023). To begin with, language has been used to dissociate population issues from control and human rights abuse, as it would have been in the past. Population control issues are now intertwined with social justice lingua, making it difficult to make conclusive observations on the extent to which population control practices are alive today (Bhatia et al. 2024). Platforms such as Family Planning (FP) 2030 were set up with the aim of promoting access to family planning as a human right. It was convened by BMGF in collaboration with USAID, the UK government, the UN and NGOs (Hardee et al. 2014). This arrangement is problematic for the following reasons: BMGF, the convenor and major financier of FP 2030 and the larger family planning ecosystem, is a not-for-profit organisation but operates like a commercial entity, often using grants for market research, supply chain management of commodities and market creation (Howerton 2021). The BMGF deploys a top-down approach in its family planning programming engagements, as evidenced in its lobbying of governments for favourable family planning policies. Its granting mechanism displays unequal power relations, in that the foundation dictates the programming agenda of its 'partners' via co-creation and, in some instances, deploying its own staff in the

grantee board of directors (Howerton 2021). Population control is still present, and it exhibits itself in the top-down approaches often benefiting elites and least useful to those who purportedly need the services (Bhatia, Hossain, Ghosh & Salignac 2024).

The family planning agenda is driven by Malthusian principles, where poverty is still blamed on individuals instead of capital and markets, and the pressure to avert a socioeconomic crisis like climate change focuses on populations in the Global South who have little to do with issues, such as carbon emissions (Wilson 2018). Emancipation of households from poverty is increasingly feminised, with more women co-opted to provide labour at different levels, including sustaining global value chains (Howerton 2021). Malthusianism is linked to racial supremacy, where the Global South is presented as hypersexualised and sexually deviant, promoting colonial religious ideologies that influenced policies decades ago (Wilson 2018).

Currently, even though family planning initiatives are designed for and run under the principle of voluntariness, the philosophy is still in question. Notably, whilst feminist organisations and social movements in the family planning discourse and practice, agitated for a shift from population control and the setting of targets to voluntarism and informing norms and normative frameworks right from ICPD in 1994, complexities around voluntariness are numerous. Population and sustainable development, for instance, are political processes, influenced by competing interests of governments, the private sector and donors. Focusing on behaviour change at the individual level takes away the focus from other external factors that influence access to contraception (Nandagiri 2021). In addition, criticisms have been levelled against FP2020 targeting 120 million contraceptive users, a regression from the human rights perspective that lent itself to ICPD 1994, where it was considered a regressive move to population control, since the principle of voluntarism would potentially be lost. Concerns were equally raised about the targeting of the 120M, who would potentially be the urban populace

who have more access to contraception, compared to those in rural areas and are underserved (Hardee, Croce-Galis & Gay 2017).

The foregoing sections have demonstrated that CSO engagements in family planning are intertwined with historical, political and economic nuances that continue to shape reproductive governance nationally and globally. Although CSOs intentionally promote access to contraception with a rights-based connotation, family planning programming is greatly influenced by technocratic approaches, donor dominance and population control logics. These factors reproduce racialised and gendered notions positioning women and adolescent girls as demographic and economic targets instead of individuals with rights. Following the gaps identified around the implementation of ASRH laws and policies and the uncertainties around the role of CSOs, it can be deduced that family planning interventions are not inherently emancipatory as they focus on behaviour change and population control.

The next section focuses on the study's theoretical framework, reproductive justice upon which this study is anchored taking into consideration the emergent issues delved into in the previous sections, gaps and opportunities around SRH programming and those targeting adolescent girls and adolescent pregnancy from a social justice perspective.

## **2.5 THEORETICAL FRAMEWORK**

This section presents the theoretical framework adopted in this study, namely, reproductive justice theory. In the process, - the history of reproductive justice theory is reviewed; the main tenets of the theory discussed; debates and critiques around the theory deliberated, its application to policy and practice outlined and finally, its relevance to this study is elaborated.

### **2.5.1 Defining reproductive justice**

The Asian Communities for Reproductive Justice (ACRJ) defines reproductive justice (RJ) as *“physical, mental, spiritual, political, social and economic wellbeing of women based on the full achievement and protection of women’s human rights”* (Sister Song Women of Color Reproductive Justice Collective 2007: 4). It is based on three interconnected human rights, which are:

- the right to have a child under the conditions of one’s choosing.
- the right not to have a child using birth control, abortion, or abstinence.
- the right to parent children in safe and healthy environments, free from violence by individuals or the state (Sister Song Women of Color Reproductive Justice Collective 2007: 4).

### **2.5.2 A brief history of reproductive justice theory**

The term “reproductive justice” was coined by Black women and women of colour in the United States, prior to the ICPD meeting in 1994, after their long history of exclusion and marginalisation in sexual reproductive health discourse and activism. Research has shown that activism towards women’s agency and choice over their sexual and reproductive health straddled decades. Between 1870 and 1900, there was a voluntary motherhood movement led by white women who demanded a shift from motherhood by coercion to motherhood by choice. Later, birth control movements and activism against eugenics ran between 1910 and 1920 (Sasser 2023). A family planning movement led by male medical professionals between the 1920s and the 1960s was not necessarily driven by the need for women’s autonomy and equality. During the 1970s and 1980s, a push for the right to choose encapsulated under “reproductive rights” emerged (Diaz et al. 2022). Other pivotal moments that contributed to the evolution of reproductive justice in the US were the Supreme Court ruling on *Roe v. Wade* (1973), where the courts affirmed that women had a right to abortion services without interference from government. To add to this, there was the Hyde

Amendment Law in 1976 that banned the use of federal funding for abortion services except for specific instances, such as incest and rape.

During this period, reproductive rights movements were predominantly led by white heterosexual women who failed to recognise the diverse experiences of poor white women and women of colour in relation to reproductive health (Ross 2020). Throughout American history, Black American, Asian, and Latina women faced discrimination regarding their sexual reproductive health; for example, they were made to undergo medical experimentation without consent, pressured to use contraceptives and forced to undergo sterilisation (van der Waal 2025; Ross 2017). White women, therefore, have been agitating for the right not to have children via abortions, while Black women and women of colour were struggling to reinstate their reproductive autonomy and fight reproduction oppression.

Reproductive justice is exemplified in three ways - reproductive rights, sexual reproductive health and social justice. Reproductive rights refer to a group of liberties and rights granted to individuals with reference to their reproductive health. These rights are anchored on human rights principles, such as non-discrimination and equity as articulated in normative human rights frameworks and adopted in national legislations and policies (Tucker et al. 2019). Legal protections for sexual reproductive health are articulated in instruments such as the Universal Declaration of Human Rights (UDHR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These frameworks pronounce and provide safeguards against SRH violations, including protection against sterilisation and insufficient access to appropriate healthcare (McGranahan et al. 2021). Additionally, sexual reproductive health is a core component of reproductive justice, as it refers to access to services for individuals that need them. Provision of SRH services is influenced by existing health infrastructure, policies, health service providers and what is morally permissible (Parker 2020). Finally, reproductive justice is about social justice, which refers to the fair distribution of resources, opportunities and rights, recognising that, while

rights apply to all, access to the same is nuanced and often influenced by contextual factors which include laws, policies and culture (Khanna et al. 2022).

Reproductive justice aims to ensure that women's sexual and reproductive health rights are deployed in an equitable and comprehensive manner by aligning them with universal human rights standards and values (Ninsiima et al. 2020). These tripartite rights under reproductive justice play out in a complex web of factors, including reproductive choice, reproductive autonomy, intersectionality, political power and centralising the experience and plight of the marginalised and excluded women and girls (Macleod et al. 2017). The multiplicity of considerations demands nuanced approaches to individual women's capacity to fully access their sexual and reproductive health rights. Equally, a woman's body is a place of political and social contestation since women exist in social circumstances that give them worth and repercussions (Crawford et al. 2023; Daigle & Spencer 2022; Crawford & Andreassen 2015).

On the other hand, intersectionality is an essential element of reproductive justice as it relates to the interaction and amplification of systems that propel inequality, including capitalism and white supremacy (Sasser 2023). Intersectionality emerged from the Black feminism movement in the US during the 1960s and 1970s, emphasising the interconnection of race, gender, ethnicity, and class. It recognises that power dynamics, oppression, inequality, and social exclusion influence individuals' experiences, including health-seeking behaviours and access to services (Muirhead, Milner, Freeman, Doughty & Macdonald 2020). Specifically, intersectionality challenges neoliberal notions on individual choices and situates a woman and her reproductive realities in a complex web of macro-level factors, including policies that perpetuate unequal power relations which exacerbate inequality and reproductive oppression (Ross 2020). Overall, the reproductive justice theory re-politicises the sexual reproductive health of women by analysing the influence of policies and distribution of resources across all groups of women and takes cognisance of the impact of inequality on women's health (Morison 2021).

### **2.5.3 Reproductive justice and adolescent sexual reproductive health and rights**

Reproductive justice is an analytical tool and framework for political activism, as it involves the right to have children, which covers sex education, maternal health care and assisted reproduction. The right not to have children via contraception, sex education and abortion, as well as the right to have children under safe environments which include access to antenatal and postnatal care. All these rights are domiciled under the human rights of women to health, privacy and education. At the core of reproductive justice are the experiences of marginalised and excluded women and girls, that are influenced by identity markers, including age, race, ethnicity, and these intersect with social justice issues, including poverty (Furio & Yuen 2022). While reproductive justice originated as a lens for interrogating the alienation of adult women's rights, this study focuses on adolescent girls, who, despite their age, have SRH needs to be addressed.

Section 2.2 discussed the barriers to the implementation of ASRH policies in Kenya; key to this was age, by law, adolescent girls are children and this restricts adolescents' capacity to consent SRH services, which affects their reproductive choices and autonomy (Kreniske et al. 2023).

It is for this reason that adolescent girls as a collective can be considered an excluded and marginalised group, from a reproductive justice perspective. Furthermore, Section 2.2 pointed out gendered norms within the SRH continuum as influencing access to SRH rights, especially gendered roles in intimate partner relationships, leading to unequal power relations. To illustrate this, a study by Lince-Deroche et al. (2015) found that adolescent girls who had received information on contraception were not able to act on it as their male partners disapproved. A reproductive justice lens earmarks intersectionality as a pivotal element in access to SRH rights, and gendered norms qualifies as one of the factors that influences adolescent girls' access to SRH services and information.

Sexual reproductive health issues play out in an ecosystem of political conservatism, religious fundamentalism and cultural relativism which often override reproductive choice from a woman or girl. These extreme perspectives infiltrate systems that are legally charged with the responsibility of protecting women's rights through services, legislation, policies and administrative action. The Supreme Court in the US, for example, in overturning the ruling on *Roe v. Wade* 1973 exemplified how the justice system can work against the very rights that constitutionalism expects them to protect (Hyatt et al. 2022). As a result, women and girls are unable to exercise their agency and bodily autonomy based on government, religious and societal structures exercising power over them.

Reproductive justice grew out of women of colour agitating against reproductive oppression through organised groups such as the Combahee River Collective, a group of twelve women who originally coined the term “reproductive justice” (Ross 2017). Transnational activism that led to the inclusion of reproductive justice in mainstream population platforms like the ICPD and policies was one of the accomplishments of this collective and other civil society initiatives (Ross 2020). Likewise, civil society organisations largely contribute to social change, especially through collective health advocacy and thought leadership from a rights perspective. The Joint Action for Reproductive Justice in South Korea, for instance, positioned abortion as a social justice issue, advocating for reproductive rights and influencing legal changes, including the Constitutional Court's 2019 decision on abortion (Kim et al. 2019).

Given the nuances of adolescent sexual reproductive health and rights, the reproductive justice paradigm provides a basis for assessing power dynamics in SRH, particularly those that influence and control access to SRH information and services targeted at adolescent girls. Finally, reproductive justice theory identifies paradigms that need to be resisted for adolescent girls to reclaim their bodily autonomy.

#### **2.5.4 Reproductive justice theory as a research lens**

Reproductive justice theory was developed to bridge a gap in the pro-choice discourse where the plight of women of colour was overlooked, and it has gained momentum across social movements, academia and health service providers (Ross 2020). It was initially applied as a conceptual framework for activism and SRH programming and then later used as a theoretical framework for empirical research (Morison 2021); however, despite the reception that reproductive justice has received in the recent past through SRH programming, its uptake in research has been low. Lidell (2019) noted the limited uptake of reproductive justice theory in social work research and publications, even though social justice is central to social work's philosophical foundations.

Similarly, there is obscurity in the uptake of the reproductive justice theory in social psychology. Morison (2021) argues that social justice scholarship is not mainstreamed in psychology due to the discipline's tendency to apply positivist lenses in research and not question power dynamics. Eaton and Stephens (2020) also observed that critical feminist paradigms were scarcely adopted in psychology research due to a culture of removing an individual's experience from the systems around them. These examples demonstrate the dearth of cases applying reproductive justice theory in research, especially in fields that relate to and impact women's sexual reproductive health.

Reproductive justice theory has been adopted as a theoretical framework for studies across academic and technical disciplines. Potvin (2018) applied this theory in her study which interrogated the extent to which Canada's Muskoka Initiative described and addressed maternal, newborn and child health (MNCH) as a global development issue. The study found that Canada's approach to maternal health was risk-centric, focusing on medicalisation and technocratization as means through which access to medical care in developing countries, could be increased. Potvin's study framed from a reproductive justice lens found that the Muskoka Initiative neglected to address power structures

affecting MNCH, instead focused on neoliberal tendencies that placed the responsibility for healthy children and populations on women (Potvin 2018).

Bond (2020) employed the reproductive justice theory from a theological standpoint, investigating how Black Protestant Christian women's sexual attitudes and practices, as well as their reproductive choices, were influenced by religious principles. She particularly observed that white patriarchy influenced the Black church's perspectives on Black sexuality through repressive religious beliefs regarding topics such as premarital sex, without considering the differences in how those teachings affected Black bodies. Unfortunately, the Black church's hesitancy to address sexuality contributed to the taboo around human sexuality, Black women's bodies, and reproductive autonomy, hence promoting inequalities in Black women's sexual and reproductive health. Eventually, Bond (2020) reimagined the reproductive justice theory by incorporating a womanist theo-ethic of reproductive justice, which incorporated the expansion of reproductive justice theory to include the assigned moral values of practical wisdom, resistance, and resiliency to showcase how women in her study responded to reproductive oppression.

Most recently, van der Waal (2025) applied reproductive justice theory to make visible the invisible practice of obstetric violence, a phenomenon that illuminates how pregnant and birthing women fail to enjoy the right to have children in safe environments. In so doing, her study re-politicised maternal healthcare by centralising how pregnant and birthing women experience quality of care during pregnancy and their assessment of quality-of-care relative to what health providers profess (van der Waal et al. 2023). This study expanded the reproductive justice theory by centring birth justice and by appending abolitionism to the theory as an act of resistance. Her study intently agitated for the dismantling of institutionalised violence and the systems that complement these injustices, including racism, colonialism and capitalism (van der Waal & van Nistelrooij 2024).

The examples, set out above, showcase how the reproductive justice theory was deployed as a lens for unpacking the blockers of reproductive and sexual justice for marginalised and excluded women. The theory was also used to assess policy positions and re-politicise sexual reproductive health. Findings from these studies have demonstrated that reproductive justice theory is people-centred and a pragmatic approach that utilises the experience of the affected people to inform transformational strategies, towards addressing systemic reproductive oppression. Similarly, reproductive justice theory was primal in this study as it offered an opportunity to move the experience of marginalised and excluded girls from the margins to the centre of reproductive politics. Further, the theory provides a framework to produce new knowledge on what shapes or impedes equitable access to SRH rights, for adolescent girls.

#### **2.5.5 Contextualising African feminist thought within the reproductive justice theory**

To sufficiently apply the reproductive justice theory in this study, one must go beyond its North American origins. The implementation of reproductive justice in the African context necessitates a critical examination of African feminist thought that conceptualises gender, power, and bodily autonomy within African epistemic frameworks. Firstly, the definition of RJ starts with an aspiration to have women and girls fully access their individual rights to have children, not to have children and to parent children in safe environments (Ross 2017). Secondly, African feminists caution the universality of access to individual rights overlook the day-to-day realities of African women and girls hence the need to curate a version of RJ that reflects on the cultural and historical contexts. Thirdly, failing to situate African feminist perspectives reproduces the epistemological hierarchies that reproductive justice theory seeks to eliminate. African feminist thought discourages the full application of frameworks designed in the global north to conduct gender analysis in the African context given the nuanced nature of African women's lives.

To this end, Mama (2007) posits that African women's political identities are complex, multifaceted and intertwined with the legacies of colonialism, patriarchy, and neoliberal governance. Mama's (2007) position is pertinent to this study because CSOs in general, and those working on sexual reproductive health in particular are a product of a post-colonial civil society framework that is highly influenced by donor goals from the global North and global health governance agendas. Equally, Mama (2011) observes that African feminist scholarship is deterred by dominant neoliberal development discourses at the global level that insist on service delivery outcomes. This de-politicises women's lives and fails to address structural factors that block women's access to their rights. Moreover, Mama's (2007 & 2011) thesis is relevant to this study as it provides a framework for assessing the extent to which CSOs principally design and implement ASRH interventions from an African feminist lens. The study sought to explore how CSOs navigated neoliberal influences cascaded through donor requirements and government bureaucracies. Mama's position strengthens RJ theory by assessing whether explicit African experience in the context of Siaya would contribute to feminist knowledge production in the context of adolescent girls' sexual reproductive health.

At the same time, Oyewumi's (1997) seminal research on the social construction of gender within Yoruba society refutes the notion of gender as a universal organizing element of African social life. Her primary argument was that social organisation in the Yoruba society was primarily by seniority in age, tied to this was the role of communal relations in African social contexts. Oyewumi's (1997) overarching thesis challenges individualism, as a determinant factor in the reproductive justice theory and as a framework for programming. Oyewumi's (1997) epistemological focus is essential for this study as it argues that African women's experiences ought to be subjected to cultural and historical rigor as opposed to universal standards. In the Luo socio-cultural life, women and girls' life choices are influenced by age, marital status and kinship and not directly by individuals as the reproductive justice theory envisions. Oyewumi's (1997)

thought demands that reproductive justice theory is contextually applied, taking cognisance of social structures that constrain adolescent reproductive autonomy.

Another African feminist scholar Sylvia Tamale's discourse on African sexualities and feminist jurisprudence is critical for this study. Tamale (2011 & 2020) indicates that pre-colonial African society had well established approaches to regulating sex and reproduction, however, these systems were eroded by Christian missionary teachings and global health institutions. She posits that young people were encouraged to explore limited forms of sexual expression and reproduction was limited to those that had gone through relevant cultural rights, yet missionary teachings shamed the African body. Through Tamale's (2011 & 2020) work, SRH discourse shifts focus from a protectionist agenda to facilitating the bodily autonomy and sexual expression as a human right. Additionally, Tamale (2011) illuminates the role of elders in intergenerational knowledge transfer that facilitated sex education in relevant and context specific ways. Altogether, Tamale argues against the victimhood lens that is applied in SRH research and how laws, social cultural norms and the patriarchal state work in tandem to suppress women's bodily autonomy. This perspective strengthens the interpretative lens for reproductive justice in the African context especially where knowledge transfer and learning on SRH is technocratized, left to judicial officers, teachers and health service providers.

Contemporary African feminist researchers indicate that African women's and girls' reproductive autonomy are limited by factors other than cultural constraints. To illustrate this, Ampofo, Beoku-Betts, Njambi, and Osirim (2022) maintain that continuous emphasis on individual behaviour change in global health interventions obscures the structural causes of adolescent girls' reproductive vulnerability such as poverty, educational marginalisation, insufficient healthcare infrastructure and oppressive legal systems (Mulumba et al. 2025). This perspective illuminates the concept of intersectionality, a core tenet of the reproductive justice theory, in the west, this would be centred around race, class and gender. Reproductive justice as a political framework counts on women and

girls to collectively mobilise to deconstruct structural oppression as it views their body as a site of political resistance against colonial and patriarchal control (Ross 2020). On the contrary, the SRH landscape in Siaya County is dominated by institutionalised CSOs and NGOisation risking depoliticisation of their work as they prioritise donor driven project outputs over community led advocacy (Mama 2020; Tamale 2020).

The African feminist thought articulated above demonstrate that adolescent girls' reproductive realities in Siaya County cannot be appreciated through a single, decontextualized viewpoint. Adolescent girls' reproductive health experiences are shaped by a complex network of colonial legacies, patriarchal governance, donor centric civil society frameworks and structural inequalities that individualised interventions constantly fail to address. Thereby, African feminist thought complements, refines and contextualizes reproductive justice theory in this study and this theoretical convergence provides the diagnostic grounds from which this study interrogates how CSOs either challenge or inadvertently reproduce the very conditions that constrain adolescent girls' reproductive autonomy.

#### **2.5.6 Reproductive justice and the adolescent right to consent paradox**

This study examines a complex and contested space where the tenets of reproductive justice intersect with child protection agendas more so provisions on age of consent as well as sociocultural norms that govern adolescent sexuality. Kenya's supreme law, the Constitution, under Article 43 guarantees the highest attainable standard of health for all. The Kenyan Children Act (2022) instructs that anyone below the age of 18 years cannot consent to sex, at the same time the Sexual Offences Act (2006) criminalizes sexual activity with minors. Equally, the *Kenya Adolescent Sexual and Reproductive Health Policy* (2015) grants adolescents the right to comprehensive sexuality education and SRH services. These political and legislative frameworks present an adolescents' right to consent paradox as they attempt to balance protective measures (protecting

children from harm) and social justice aspirations (empowering them to access healthcare. The Kenyan law regards adolescents as children lacking the ability to make decisions regarding their sexual and reproductive health (Kangaude & Skelton 2018).

Reproductive justice theory challenges this protective paternalism by affirming adolescent girls' ability for self-determination; nevertheless, child rights theory warns that unrestricted autonomy, vague structural safeguards, may render younger adolescents vulnerable to exploitation rather than emancipation. The comprehensive implementation of RJ's principles is conceptually and ethically complex concerning adolescents, considering their age and ability to consent to services and sexual activity. Scholars like Du Plessis & Macleod (2023) and Braeken et al. (2021) contend that policy should depart from the dichotomous perception of adolescents as either vulnerable minors or autonomous agents. They advocate for a nuanced approach to adolescent sexual reproductive health interventions in accordance with the UNCRC's focus on evolving capacities. Consequently, adolescent reproductive justice should consider age segregated capacities while examining the structural factors including poverty and gender inequality that constrain choice across all ages (Banke-Thomas et al. 2022).

This study engages this tension by adopting the position of Kismödi, Cottingham, Gruskin, and Miller (2022) who posit that the rights of adolescents to protection and autonomy are not contradictory but rather exist on a developmental continuum necessitating contextualized, age-appropriate, and culturally sensitive considerations.

### **2.5.7 Critiques of reproductive justice theory**

The critiques of the reproductive justice theory have been embedded throughout the preceding subsections rather than confining them to a single section. Section 2.5 examined its Eurocentric origins, more so the underlying presumption that

individual rights are universal. Section 2.5.5 discussed the application of reproductive justice via African feminist thought, mainly through Tamale's (2011; 2020) recovery of pre-colonial African reproductive knowledge systems that were destroyed by colonial governance. Mama's (2007; 2011) examination of how neoliberal development discourse limits African feminist structural analysis, and Oyewumi's (1997) deconstruction of gender as a Western imposition on African social organisation. In the adolescents' right to consent paradox covered under sub-section 2.5.6. The study took an unassailable stance in line with the UNCRC's evolving capacities framework, addressing the tension between protective measures as per the Kenyan Children Act (2022) and reproductive justice aspirations observed under the constitution as well as the *Kenya Adolescent Sexual Reproductive Health Policy* (2015). This section incorporates the critiques summarised above into a broader framework. It specifically addresses the reproductive justice's over-emphasis on abortion rights and its lack of clear research method both critical for a doctoral study using reproductive justice as a theoretical framework.

Reproductive justice theory as developed in the global academy where its empirical application has overly focused on abortion rights, excluding other reproductive oppressions faced by women in the Global South, like dignified maternity for all women and access to contraceptive counselling and services (Dierickx et al. 2021; Potvin 2018). This critique is relevant to this study since CSOs engaging in Siaya County engage on a broad range of SRH issues including maternal health, access to SRH services and information as well as advocacy. A theoretical framework solely focused on abortion rights would be inappropriate and would offer an incomplete picture of CSOs engagement in the county. The contribution of this study is therefore not only empirical but theoretical as it expands the documented range of programmatic and governance contexts to which reproductive justice theory can be applied.

Given the limited utilisation of reproductive justice theory in empirical studies across technical fields due to its multidisciplinary nature, analysts note that it fails

to have a clear methodology, hence, its concepts may be misunderstood and underutilised in research (Morison 2021). Reproductive justice theory was deployed as an analytical framework along the research design in the following ways, first, the deductive coding framework for the first stage of thematic analysis was derived from the tripartite rights framework which includes the rights to parent in safe and healthy environments, to have children, and to not have children (Sister Song Women of Color Reproductive Justice Collective 2007). Second, rather than being acknowledged theoretically, intersectionality, a fundamental component of reproductive justice was used as an active analytical tool (Ross 2020; Sasser 2023). Third, reproductive justice's insistence that reproductive health be situated within the political economy of power, control, and hegemony was explicitly used to test the donor-CSO relationship as well as the CSO-state relationship (Morison 2021; Crawford et al. 2023). The operationalization made sure that reproductive justice theory worked as a generative analytical tool that influenced the study's search, findings, and interpretation of those findings.

In response to these critiques, the study embedded three adaptations, first, by integrating African feminist thought discussed in section 2.5.4 to contextualise African experience negate North American assumptions. Second, the study extended focus from abortion rights by exploring the full spectrum of programmatic strategies deployed by CSOs in Siaya County. Third, the tension between rights frameworks and Kenyan socio-cultural realities were treated as a potent analytical ground rather than evidence of the theory's impracticality. Consequently, this study contributes to the theoretical expansion of reproductive justice scholarship by showcasing how the theory can be contextualised and methodologically operationalised for qualitative empirical research on civil society and adolescent reproductive health in an African development studies setting.

### **2.5.8 The relevance of reproductive justice theory to this study**

As mentioned above, there is limited use of reproductive justice theory in empirical research, more so on adolescent sexual reproductive rights in Africa

and Kenya specifically. This study contributes to a body of knowledge on how to apply this in development scholarship and as part of political activism. Reproductive justice theory was most suitable for this study as it laid out the multiple and intersecting factors that influence civil society organisations' contribution to adolescents' sexual and reproductive health rights. The explication below showcases a conceptual visualisation of how the key tenets of reproductive justice - the right to have children, the right not to have children and the right to have children in safe environments - intersect with individual factors, as well as external factors.

This theory is anchored on human rights principles as well as the implementation of normative human rights frameworks. In Kenya, adolescents' SRH rights are anchored on legal and policy frameworks, aligned to different human rights instruments. This study sought to assess the extent to which strategies that civil society organisations employed are effective from a human rights perspective. Central to this study is the extent to which CSOs apply the principles of participation, non-discrimination, and accountability in their interventions on adolescent pregnancy. Historically, adolescent SRH interventions in Kenya have been centred around public health (Oronje 2013), a view corroborated by Forman (2019), who underscores that human rights are scarcely incorporated into health studies, policy and management discourse. This study framed the SRH rights of adolescents to include access to SRH information and services, all of which, if accessed, facilitate an adolescent girl's bodily autonomy and reproductive agency.

Reproductive justice theory engages SRH issues beyond individual choice and moves towards intersecting community and systemic issues that influence access to, and enjoyment of, an adolescent girl's SRH rights. The theory recognises that marginalised and excluded people have equal human rights but experience oppression differently (Messing et al. 2020). This perspective was relevant to this study since adolescent girls in rural areas harbour unique experiences based on their socioeconomic backgrounds and they faced with

varied vulnerabilities due to their age and socioeconomic factors. An evaluation of the relevance of approaches and interventions based on contextual realities and individual needs was, hence, critical to this study.

This study viewed adolescents' SRH rights in their broadest spectrum, aligning them to those under the reproductive justice theory, covering the right to have children, the right not to have children using birth control, abortion or abstinence, and the right to parent in a safe and healthy environment. As such, organisations focusing on one or more of the following interventions were engaged; provision of comprehensive sex education, comprehensive abortion care and post-abortion care, and ante- and post-natal care (including contraception). Using this framework, the study reviewed how CSOs are delivering their interventions across one or all these rights, with a view of unearthing their positionality as guided by their broader organisational missions and strategies as well as external influences like donor and government controls. Mindful that the SRH space is highly regulated by government through policies, legislation, and administrative factors, the study sought to explore how organisational priorities, sociopolitical contexts, and human rights interact to deliver for adolescent girls.

The reproductive justice approach interrogates power relations, given that power, control and hegemony impact women's health, especially reproduction. Linked to this is the place of politics and governance in adolescent SRH. The study interrogated the extent to which programmatic strategies are influenced by individual and systemic changes at the individual, community, county and national levels. Civil society organisations operate in environments that are propelled by macroeconomic policies and weak institutions that are characterised by continuous sectoral reforms aimed at cost-effectiveness, at the expense of women's and girls' wellbeing, all of which increase inequality (Capelli 2019; Bakhru 2017). The health sector continues to attract neoliberals, the most notable being the promotion of public-private partnerships (PPPs) that have led to the privatisation of public goods, such as health care (Bendix & Schultz 2018). This points to how politics and economics work in congruence and how these

relationships shape CSOs' diverse roles in the implementation of adolescent SRH interventions. Given that CSOs have service provision and influencing roles, reproductive justice theory recommends approaches that link local and global-level work, as well as, service delivery, legislative reforms, and implementation, as well as active citizenry for change through movement building and social mobilisation.

Through this study, the application of reproductive justice theory would be expanded, given the dearth of information on its use in the academy and in practice, in an African context.

## **2.6 CONCLUSION**

This chapter provided a comprehensive examination of adolescent sexual and reproductive health rights within global, regional, and national frameworks, establishing the foundation for understanding civil society organisations' contributions to adolescent reproductive justice in Kenya. The chapter has illuminated the complex interplay of factors that influence the implementation of adolescent sexual reproductive health policies and the critical role of CSOs as intermediaries between policy frameworks and community-level realities. The review demonstrated that while Kenya possesses robust legal and policy frameworks supporting the SRH rights for adolescents, from constitutional provisions to sector-specific policies, significant implementation gaps, however, persist. These gaps manifest through policy misalignments, particularly the contradictory age requirements for sexual consent versus service access, inadequate health financing, and structural disconnects between national and county governments. The analysis reveals that despite progressive policy intentions, adolescent girls continue to face barriers accessing comprehensive SRH information and services, with these challenges exacerbated by sociocultural biases, religious opposition, and economic constraints.

The examination of CSO operations reveals organisations operating within a complex ecosystem ranging from donor dependency, short-term funding cycles,

to competing demands for accountability to multiple stakeholders. The literature demonstrates how neoliberal influences have shaped CSO identity through processes of *NGOisation* and managerialism, potentially compromising their capacity for transformative social change. The chapter brought to the fore the role of CSOs in the family planning context where CSOs emerge as both service providers and advocates, yet their effectiveness is constrained by donor priorities, government regulations, and the broader political economy of development aid. Significantly, the review highlights the growing backlash against SRHR globally, exemplified by policies such as the Mexico City Policy and increasing religious fundamentalism, which create an increasingly challenging environment for CSO advocacy and programming. These regressive trends underscore the necessity of understanding how CSOs navigate political constraints while advancing reproductive justice principles.

The theoretical framework of reproductive justice emerges as particularly relevant for understanding these dynamics, offering a lens that moves beyond individual choice to examine structural and systemic factors that influence access to SRH rights. The theory's emphasis on intersectionality and the experiences of marginalised groups provide a framework for understanding how age, gender, socioeconomic status, and other identity markers intersect to shape adolescent girls' access to reproductive autonomy. Reproductive justice theory was juxtaposed with African feminist thought to make it context specific and relevant to the realities of women and girls in the continent. An expanded view of reproductive justice showcases the role of colonial legacies, neoliberal approaches in the global CSO architecture and cultural relativism as aspects that influence access to adolescent SRH rights. Altogether, an African centred reproductive justice theory contends that CSOs are likely to be agents of social change or facilitators of reproductive injustice. This literature review establishes that examining CSO contributions to ASRHR requires understanding multiple intersecting factors: the policy environment within which they operate, the structural constraints they face, the effectiveness of their programmatic

strategies, and the broader political and socioeconomic contexts that shape their work.

The gap between progressive policies and implementation realities suggests that CSOs play a crucial mediating role, yet their capacity to deliver transformative change remains constrained by systemic factors. The review thus sets the stage for empirical investigation into how CSOs in Siaya County navigate these complexities while working to advance adolescent reproductive justice. It highlights the need to examine not only what CSOs do but how external factors including donor priorities, government policies, cultural norms, and political dynamics shape their strategies and effectiveness. Furthermore, the literature review establishes reproductive justice theory as an appropriate analytical framework for understanding these dynamics and assessing the extent to which CSO interventions address the structural determinants of reproductive oppression, rather than merely providing technical solutions to complex social problems. Through this comprehensive review, the foundation is established for exploring the primary research objective - describing and exploring CSO contributions to adolescent reproductive justice in Kenya - while also addressing the secondary objectives related to internal and external influencing factors, strategy effectiveness, political and socioeconomic influences, and policy recommendations for advancing reproductive justice.

## CHAPTER THREE: RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

This chapter details the research methodology and processes applied in this study. It explains the research design, sampling methods, procedures, and data-generating techniques used to gather data from study participants. The chapter also describes the data analysis process and further outlines the trustworthiness and rigour, as well as ethical issues factored in during the research process.

### 3.2 THE CHOSEN STUDY SITE

Siaya County, one of 47 counties in Kenya, was chosen as a study site for several strategic reasons that supported the primary and secondary objectives and enhanced the study's capacity to produce insightful knowledge about how CSO contributions to adolescent reproductive justice in Kenya. Demographically, Siaya had a population of 993,183 in 2019, and this was projected to increase to 1,097,141 in 2025 and 1,136,553 in 2027. Significantly, 36.6% of the population is between 15 and 24 years old, establishing a substantive adolescent and youth demographic context that was central to the study (Kenya National Bureau of Statistics 2019). The county comprises six sub-counties, namely, Alego Usonga, Gem, Ugenya, Ugunja, Bondo and Rarieda, and 30 county assembly wards (County Government of Siaya 2023). The study sought to investigate how CSOs worked in these locations and whether there were substantive differences based on the contexts. The CSO's areas of implementation are discussed in Chapter 5.

Siaya is a rural community, and its population primarily consists of the *Luo* ethnic group, with minority groups like the *Luhya* located in border regions. The predominant religious belief among the population is Christianity, while Islam and many African traditional religions are also present. On the socioeconomic front, the primary economic activity is agriculture, which includes plant cultivation,

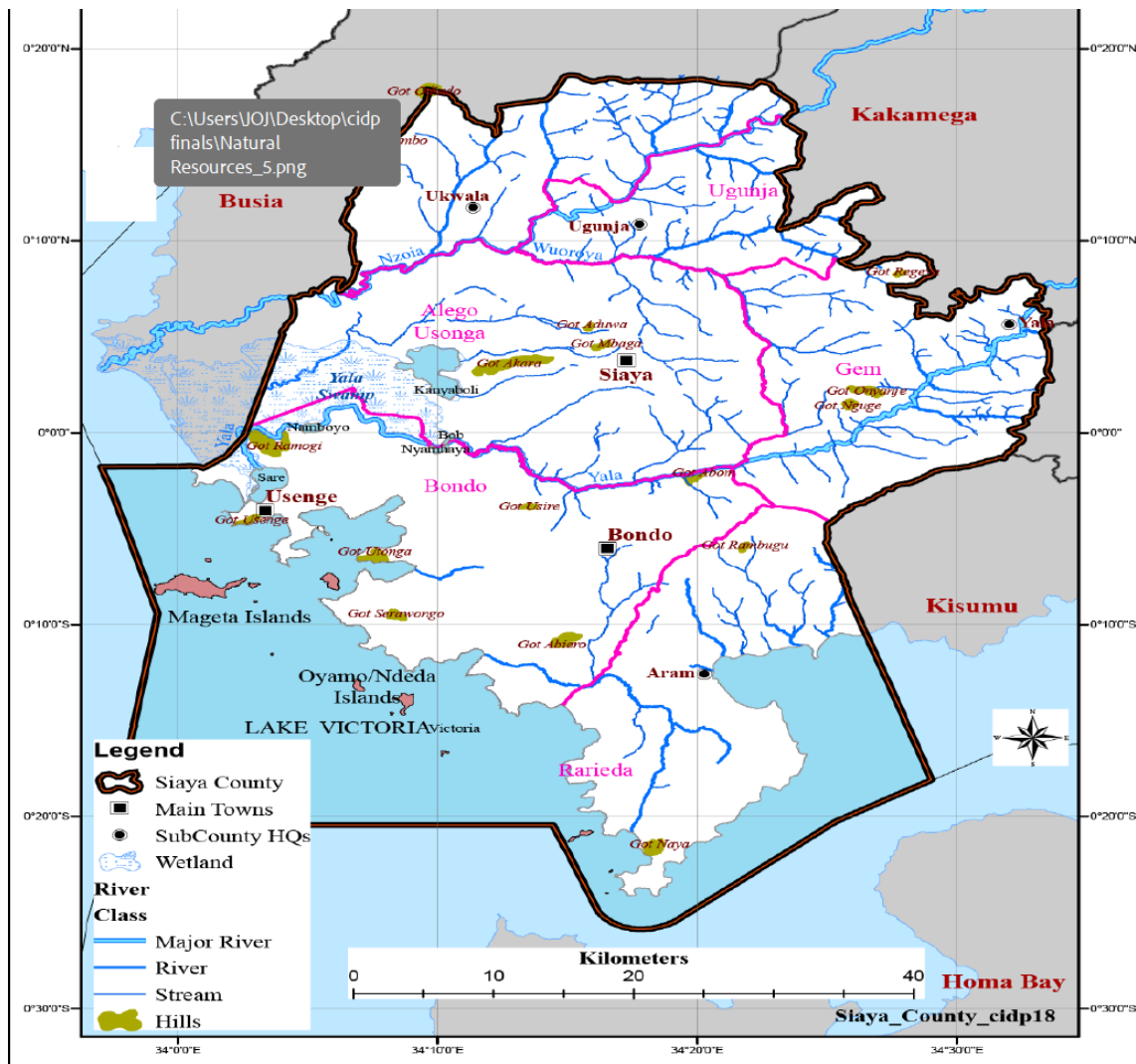
animal rearing, and fishing (Kenya National Bureau of Statistics 2023). Siaya's monetary poverty rate is 33.1%, marginally lower than the national rate of 35.7%; the county possesses a Human Development Index (HDI) score of 0.46, in contrast to the national average of 0.56 (Kenya National Bureau of Statistics 2023). The county's socioeconomic and cultural contexts were relevant in unearthing how civil society organisations navigate different cultural norms and practices related to adolescent SRH and how they adapt their approaches to different geographic and social contexts.

Siaya County was selected due to its high adolescent reproductive health indicators, making it a critical setting for examining CSO interventions. Related to this is the fact that Siaya's adolescent pregnancy rate is at 20% compared to the national average of 15%; furthermore, HIV/AIDS is a major burden for households in the county. In 2022, almost half (59%) of new HIV infections in Kenya, among adolescents aged 10-19, were concentrated in 10 counties, with Siaya County accounting for 80% of the new infections (Republic of Kenya, National Syndemic Diseases Control Council & National Council for Population and Development 2023).

The high prevalence of HIV/AIDS over the years catalysed significant programming by both government and civil society organisations targeting adolescent girls and young people. As a result, donor-funded HIV/AIDS programmes spurred the growth of CSOs implementing health-related programmes in the county (Awuoche et al. 2024). The existing presence of CSOs in the county presented a timely opportunity to examine their programming approaches aimed at promoting adolescent sexual reproductive health, beyond HIV/AIDS programming. This expanded perspective is in line with the reproductive justice theory, which moves beyond interventions that tackle individual girls to assessing structural issues that impede girls' reproductive autonomy. In addition, the selection of Siaya County aligned with reproductive justice theory's emphasis on intersectionality. The county was purposefully identified to gain different perspectives from CSOs on factors that influence

adolescent sexual and reproductive health, like marginalisation based on rural location, gender, and poverty. This convergence of many types of marginalisation and exclusion allowed for an analysis of how structural variables other than human choices, influence reproductive outcomes, which supports reproductive justice theory's analytical focus on systemic inequities.

**Figure 3.2 Map of Siaya County**



**SOURCE** (County Government of Siaya 2023)

### 3.3 THE RESEARCH DESIGN

A research design comprises the overarching strategies and processes, ranging from the paradigms to data collection and analytical approaches in a research inquiry (Creswell 2014). The selected design is dependent on a broad range of factors, including the research questions to be answered and the overall research objectives (Creswell & Poth 2018). This study adopted a qualitative research design which is suitable for investigating social phenomena in their natural context and gathering participants' experiences and perspectives (Denzin & Lincoln 2018). The study sought to explore civil society organisations' engagement with adolescent sexual reproductive health and rights programming; this inquiry, hence, entailed exploring the strategies CSOs deployed in their programming, challenges faced and their perceived notions of success, thus, rendering a quantitative methodology ineffective (Dervin & Dyer 2016). The reproductive justice theory underpinning this study underscores the significance of centering the perspectives and voices of the marginalised, in this case, adolescent girls in a rural area, as such a qualitative research design was deemed most relevant (McGrath, Palmgren & Liljedahl 2019).

Civil society organisations' work is marred in complexity because they navigate varied factors, including, donor and government regulations as well as their constituents' needs. These interconnected issues necessitated a qualitative approach that could capture the multiple and intersecting realities that a quantitative approach would not cover (Hamilton & Finley 2019). Additionally, a descriptive qualitative design approach was applicable as it sought to provide detailed experiences from civil society organisations on their day-to-day ASRH programming. This approach enabled the researcher to interrogate "how" CSOs contributed to adolescent sexual reproductive health, from a reproductive justice perspective (Kim, Sefcik & Bradway 2017).

In recognition that CSOs contribute to adolescent reproductive justice in diverse geopolitical and socioeconomic contexts, the study employed a case study

design to unearth the reality of advancing adolescents' reproductive justice in a rural context, hence the selection of Siaya County as a geographic case study as described in Section 3.3, while the specific CSOs sampled served as the units of analysis.

Further, the study utilised a descriptive qualitative research design as it sought to unearth subjective participants' experiences which included intangible elements such as sociocultural issues that could not be numerically captured (Saunders et al. 2015). Finally, a qualitative research design takes a naturalist standpoint, seeking to understand phenomena in their contexts without an attempt to manipulate the topic under investigation. In this case, the study was focused on unearthing the realities of sexual reproductive health rights' programming for adolescents in a rural context (Denzin & Lincoln 2018).

### **3.4 RESEARCH PHILOSOPHY AND PARADIGM**

A research paradigm is a set of beliefs, worldviews, and philosophical presumptions regarding the ontological, epistemological, and methodological decisions that guide certain approaches to studying the concerned issue (Flick 2022). The philosophical assumptions utilised in this study were informed by the primary and secondary research objectives and grounded in the reproductive justice theory. Chapter 2 demonstrated that adolescent girls' access to the right to sexual reproductive health is far from being achieved, and this is influenced by actions and inactions of different players, including government, CSOs and donors. Similarly, the literature showed that SRH interventions overemphasised individual girls' choices and health outcomes, as opposed to organisational-level and systemic realities where the existing SRH policy and legislative frameworks are implemented. This interpretivist paradigm is supported by the following ontological and epistemological assumptions.

Ontology refers to the assumptions about the nature of reality (Hamilton & Finley 2019). In this study reality was constructed from civil society organisations' multifaceted experiences emanating from implementing adolescent sexual reproductive health interventions. CSO work plays out within complex political and social systems, hence simple measurement approaches would not unearth these nuanced realities. Epistemology is defined as what counts as knowledge (Creswell & Poth 2018). This study adopted an interpretivist stance where civil society organisations' individual perspectives were used to generate knowledge on their contribution to adolescent girls' reproductive justice. An interpretivist paradigm was central to this study in the sense that the problem under inquiry was context-specific; in this case, the implementation of adolescent sexual reproductive health programming in Siaya County, a rural area, by diverse civil society organisations. The study participants were varied in terms of organisational structure, operating model and scope of work as recommended by Guraya et al. (2023).

Building on this interpretivist foundation, the study applied reproductive justice theory as a theoretical lens that foregrounds intersectional feminism, which refers to the interconnected nature of various forms of oppression and their impact on adolescent girls' bodily autonomy (Ross 2017). Literature in chapter two identified a broad range of factors that contribute to reproductive oppression of girls', including age, gender, socio-economic status - all of which were considered in this study. As a research framework, intersectionality suggests that multiple social identities influence social power relationships exposing people to different social advantages and disadvantages (Hirata et al. 2025). Intersectionality allowed the researcher to focus the conversations with the research participants on the needs of vulnerable and underserved groups in the health context. Using intersectionality as a frame of reference in the data collection and analysis enabled the researcher to illuminate socio-historical forces of marginalisation to better contextualise the issues of adolescent sexual reproductive health (Else-Quest & Hyde 2016). May (2015: 251) refers to this as "matrix" thinking, rather

than “single axis” thinking, to allow space for data collection that is open-ended, dynamic, and “*biased toward realising collective justice.*”

From the first conceptualisation of this study, the researcher was acutely aware that the topic had material implications for the individual wellbeing and health of adolescent girls in Kenya and would demand a research stance directed at illuminating and dissecting the complexities of minds and bodies, as sites of intersectional oppression, to offer recommendations for intervention or policy change. As such, empathy and rapport-building were key elements in the data collection process. The researcher knew the study participants were simultaneously people with a particular view of what the boundaries of adolescent sexual reproductive health and rights were and service providers with a particular affinity to work with young people. This meant that they presented their narrations in the interviews as shaped by their socio-cultural context and the meanings and salience they added to this. The interviews often touched on issues of gender, ethnicity, sexual orientation, and religion. These aspects are pointed out in the next chapter where the data vignettes from the participants are presented.

Fundamentally, this was an inquiry exploring organisation-specific programming strategies, challenges and mitigation measures. Since the study aimed at understanding the contribution of CSOs in adolescent sexual reproductive health programming, a positivist approach with pre-existing hypotheses would not suffice. Finally, this study was transformational in nature with a desire to offer policy proposals for the realisations of adolescent girls’ reproductive justice (Hamilton & Finley 2019).

The ontological, epistemological and theoretical stance in this study, hence, promoted the adoption of a qualitative case study methodology. According to Baxter and Jack (2015), qualitative case studies are relevant in instances where a social phenomenon under inquiry is context-specific but still requires multiple perspectives. Similarly, focusing on Siaya County as a case study offered an opportunity to investigate how social, political and organisational factors intersect

to influence adolescent girls reproductive justice outcomes as experienced by a broad range of CSOs working in the same area.

### **3.5 STUDY POPULATION AND SAMPLING**

#### **3.5.1 Target population**

Given the case study emphasis on Siaya County and the need to understand varied organisational perspectives, the target population was civil society organisations implementing adolescent sexual reproductive health programmes within the County. To be eligible for inclusion, the CSOs had to meet the following criteria:

1. Formal registration as an NGO or CBO
2. Actively implementing SRH projects targeting adolescent girls
3. Operational for at least 2 years, prior to the interview

#### **3.5.2 Sampling strategy**

The study employed purposive sampling, a non-probability sampling technique which is defined as the deliberate selection of a study participant due to their relevance to the research question (Lopez & Whitehead 2016). A purposive sampling approach was relevant to the interpretivist paradigm adopted in this study as it focused on depth and not statistical representativeness (Creswell 2014). The sampling strategy was also aligned with the reproductive justice theory, as it intentionally focused on selecting CSOs that delivered diverse interventions geared at promoting the right of SRH for adolescents (Creswell & Poth 2018). Furthermore, purposive sampling was relevant to the qualitative case study research as the participants were chosen for their appropriateness to the research (Ahmad & Wilkins 2024).

A purposive sampling strategy was applied at various levels to identify relevant CSOs in Siaya County. The study adopted Malterud, Siersma and Guassora's (2016) information power framework to refine the sample size; the framework posits that when a sample holds sufficient information for the research, fewer participants are required to engage. Malterud et al. (2016: 1756) outline five factors that determine whether a sample has sufficient information power, to begin with, the sampling strategy must be congruent with the research objectives, in this regard, this study had a narrow focus on CSO's experiences with SRH programming for adolescent girls allowing for in-depth discussions. Following that, sampling specificity must be apparent. In this study, the CSOs with adolescent SRH programming experience were purposely sampled. The participants shared perceptions that were relevant to the study questions. Additionally, the sampling strategy must be congruent with the theoretical foundation of the study. This study was anchored in reproductive justice theory, which concomitantly served as an analytical tool. This enabled the researcher to extract deep meanings and connections from the interviews. Further, The sampling strategy must be appropriate for the data collection strategies. The data collection for the study was primarily achieved through in-depth dialogue with CSO leadership who had a strong hold on strategic and operational realities. The interview sessions generated comprehensive information on programme strategies, challenges, survival tactics and areas of continuous improvement. Finally, the sampling strategy must have contextual relevance, and for this study that was achieved through a focus on Siaya County only to provide relevance to the overall research objectives.

The researcher used two recruitment strategies: first, internet searches, and second, consultation with umbrella bodies working on SRH in the county. Initially, the SRHR Alliance was approached to support the identification of CSOs, However, the organisation had scaled down its operations in Siaya as at the beginning of the data collection in November 2022 and did not hold a database of all CSO actors. Consequently, through the researchers' professional networks, Siaya Muungano Network, a CSO based in Siaya County coordinating all SRH

actors, was identified. Through this connection, the researcher accessed a database of thirty-five CSOs implementing SRH projects in the county, using the inclusion criteria described above.

Upon receipt of all contact information of the organisations, the researcher made calls, introducing herself to the contact persons as listed in the database. The researcher briefly explained her research objectives and gauged the participants' interest in getting involved in the research. The researcher intentionally targeted interviews with the CSO leadership or their designates, as they would have the capacity to speak to both strategic and operational experiences. Of the thirty-five identified, two organisations were excluded as they indicated that they were no longer implementing adolescent SRH work in the county.

Once the oral consultations had been conducted, twenty-five verbally agreed to participate in the study and those are the ones the researcher proceeded with. As a next step, the researcher sent out the research participants' information sheet, the ethical clearance letter from UNISA and the NACOSTI research permit via email. The intention of sending this out was to ensure that the proposed research participants had a good grasp of the research objectives and questions before fully committing to engage in the process; although twenty-five participants verbally agreed to engage, only twenty committed to being interviewed, by confirming appointment dates and times.

The researcher conducted seventeen interviews, whose details are discussed in Section 4.2, before reaching data saturation. Data saturation refers to the point at which no new data emerges from data collection, hence there is a repetition of information (Smith & Noble 2014). In line with the information power framework discussed above, the adequacy of the sample was proactively monitored against the study's main objective and specificity of the participants (Malterud et al. 2016). By the time the researcher was conducting the fifteenth interview, common challenges and programming strategies, were identified, however, by the time the researcher got to the seventeenth interview, participant information was just

reaffirming themes generated from previous interview. At the same time, data transcripts were monitored weekly to ensure that dimensions of information power were met thus ascertaining that the sample was adequate to provide an extensive analysis of the phenomenon (Hennink & Kaiser 2022).

### **3.5.3 Data collection techniques**

This study utilised in-depth interviews as the primary data collection method, in line with the interpretivist paradigm as they enabled the researcher to delve deep into the participants' experiences, in adolescent SRH programming (Maake 2021). In-depth interviews were selected to collect evidence which would support the reproductive justice theory. The interview sessions offered participants a conversational space to share how intersectional factors such as political and legal complexities, socio-cultural contexts, gender and age influenced programming strategies and positive reproductive justice outcomes for adolescent girls (Young & Atkinson 2012). Compared to structured surveys, in-depth interviews provided an opportunity for the study participants to expand and challenge the researchers' possible preconceived notions about their work, in implementing SRH programme interventions (Recknor et al. 2023).

#### **3.5.3.1 Interview guide development and testing**

The researcher developed a semi-structured interview guide based on the research questions and outcomes of the literature review. The guide listed the main ideas to be explored but also allowed sufficient flexibility for a free conversation to unfold (Mashuri, Sarib, Rasak & Alhabsyi 2022). This semi-structured interview guide covered questions focusing on - organisational background; programme interventions; policies and legislations underpinning civil society organisations' work; barriers to adolescent reproductive justice and challenges faced during the implementation of their work (the detailed semi-structured interview guide is shared in Annex C). Prior to the fieldwork, the interview guide was piloted with a representative of a community-based

organisation to assess the length, clarity of questions and whether there were any question overlaps. After the piloting, the guiding questions were modified to reflect various CSO areas of expertise and organisational focus; the questions were also made shorter while retaining their exploratory potential; repetitive probing questions were removed or combined, and more probing questions were developed to delve deeper into the intersectional themes.

### **3.5.3.2 Interviewing process**

Based on the information power framework earlier described, the researcher focused on maximising dialogue quality by facilitating deep conversations. To this end, the interviews were conversational, and questions were not necessarily deployed in any specific order. The participants had access to the questions beforehand, and the researcher offered the flexibility for them not to respond to questions they were not comfortable with (Kallio et al. 2016). Some participants, for instance, felt that they were not technically apt to respond to the question around the policies and legislations undergirding their work. As a result, the researcher focused on some participants' experiential knowledge of the policies and legislation and not technical-level knowledge (Dodds & Hess 2021). At the same time, the researcher took time to elaborate on concepts that the respondents were not clear about as part of the interviewing process; this was particularly for the questions on programmatic framing on reproductive justice (Dodgson 2019). Conceptual clarity ensured that the participants could engage meaningfully with the research questions while also exposing them to new programming concepts. The researcher intentionally built rapport with the participants pre- and during the interview to enhance trust, which was critical to achieving dialogue quality (Malterud et al. 2016). The interviews started with stories around the researcher's and participants' career journeys, fun facts about the CSOs' origins and occasional banter around politics of the day in Kenya (Bell, Fahmy & Gordon 2016).

### **3.5.3.3 Data collection timeline**

Data collection was conducted over a ten-month period commencing in November 2022 and was concluded in August 2023. The period of data collection was determined by the participants' availability and the researcher's schedule reflecting a pragmatic approach to field research. Sixteen study participants were interviewed virtually, via Zoom for logistical reasons and participant preferences. Current literature on research methodologies intimates that virtual interviewing no longer a compromise but a wholesome method with the capacity to generate in-depth data equivalent to in person interviews (O'Connor & Madge 2022). Part of the researcher's recruitment strategy was to offer flexibility around the interview modality. This was informed by requests from participants during the first participant outreach where most asked whether virtual interviews were an option and indicated a preference for that method. By aligning the data collection process with participant choices, a participant centred environment was fostered. studies have shown this level of consideration reduces participant burden and lifts the richness of the conversations (Roberts et al. 2021).

### **3.5.3.4 Virtual interview implementation**

Virtual interviews have gained traction in academic research with the advancement of digital technologies, whilst also the COVID-19 pandemic opened individuals and organisations to new ways of working (Mashuri et al. 2022). Given the geographical spread of civil society organisations in Siaya County and the mobile nature of their operations, part of the recruitment strategy was adjusted to include flexible interview modalities. Based on the researcher's experience conducting this study, the main advantage of virtual interviews was the flexibility and convenience accorded to participants (Ślęzak 2023). During the participant recruitment process, the researcher shared a range of virtual platforms that could be used, namely, Microsoft Teams, Google Meet and Zoom. Most participants were conversant with the use of Zoom, as this platform was commonly used for meetings during and after COVID-19 pandemic (Li et al. 2022).

For the researcher, the virtual interviews were economical, as there was no need to travel from Nairobi to all the sub-counties in Siaya at different times (Akyirem et al. 2024). The researcher however, incurred financial costs purchasing premium Zoom packages with higher security, longer running time and automated recording, which made transcription and storage easy.

Each interview began with a standardised opening protocol designed to establish rapport, confirm consent, and set clear expectations and meeting logistics. The researcher rearticulated the scope of the research and participants were reminded of their rights, including the right to pause, skip questions, or stop the interview at any point. The researcher explicitly confirmed participants' verbal consent to proceed, in addition to the written consent previously obtained. As conversations approached natural conclusion points, the researcher provided participants with opportunities to add any additional thoughts or experiences they felt were essential but had not been covered. Before ending the recordings, the researcher summarised key themes that had emerged during the conversation, providing participants opportunities to clarify or correct any misunderstandings.

The researcher explained the next steps, including approximate timelines for transcription, analysis, and potential follow-up contact if clarification was needed. Post-interview procedures included immediate completion of reflective notes while the conversation remained fresh in the researcher's memory. These notes captured technical issues encountered, emerging themes, and potential areas for follow-up in subsequent interviews.

### **3.5.3.5 Managing challenges with virtual interviews**

Based on the researcher's experience, virtual interviews came with unique difficulties that call for proactive management procedures, the most prominent being internet connectivity, a common challenge in rural areas (Malephane 2022). To surmount this difficulty, the researcher used several flexible techniques

that preserved the quality of the interviews in consideration of technological constraints. At the start of each interview, the researcher highlighted that connectivity was a likely challenge, and both participant and researcher talked through how to handle it. One of the options floated in the event of an unmanageable network, was a rescheduling of the interview, although this never happened. To maximise bandwidth utilisation while maintaining crucial aspects of in-person interaction, camera usage was carefully controlled. Cameras were turned on at the start of each interview for introductions and rapport-building. This helped with facilitating visual connection and non-verbal communication that improved the development of trust. For appropriate closure and last-minute clarifications, cameras were also turned back on at the conclusion of interviews.

Participants were requested to be flexible with the timing of the interview, acknowledging that technical issues could occasionally cause sessions to go longer than the 45 minutes that were originally planned. This adaptability was crucial for maintaining the interview's flow and guaranteeing that, despite intermittent technical difficulties, significant themes could be thoroughly examined.

#### **3.5.3.5 Data security and management**

Throughout the virtual interview process, consideration was given to data security and privacy. To improve security, meeting passwords were shared via different channels, and all recordings were automatically saved in password-protected, encrypted files that only the researcher could access (Keen, Lomeli-Rodriguez & Joffe 2022). Privacy protection was maintained on both sides of the virtual interview. On the researcher's side, interviews were conducted in her private home office. Participant privacy was assessed and ensured through direct inquiry at the beginning of each interview; the participants were asked to confirm that they were in a private location where they could speak freely. The study participants chose to conduct interviews from their offices, vehicles and homes, where confidentiality could be maintained.

Following each interview, comprehensive data security protocols were implemented to protect participant confidentiality and ensure data integrity. Zoom cloud recordings were downloaded to the researcher's password-protected computer within 24 hours of interview completion, after which cloud copies were permanently deleted. Downloaded files were immediately transferred to encrypted, password-protected folders with access limited to the researcher. All interview files were renamed using predetermined participant identifier codes, removing any personal identifying information from file names. A separate, securely stored master list maintained the connection between participant codes and organisational identities, accessible only to the researcher. Original email communications containing scheduling information and signed consent forms were archived in encrypted folders separate from interview recordings, ensuring that consent documentation could be accessed if needed while maintaining separation from interview content.

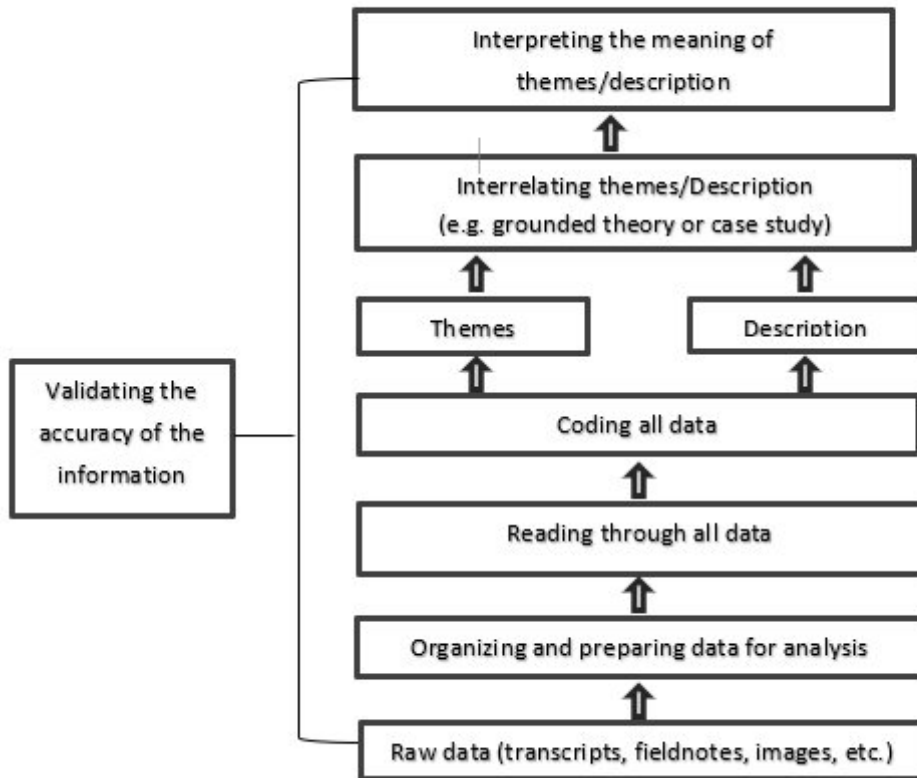
Interview transcription employed a multi-stage process, set out to ensure accuracy and confidentiality. The initial transcriptions were generated using Zoom's automated transcription feature; this provided rough transcripts immediately following interviews. Notably, these automated transcripts, preliminary, required manual review and corrections. The researcher reviewed and corrected all the automated transcripts, listening to the complete interview recordings while editing for accuracy, clarifying unclear sections, and noting non-verbal elements, such as pauses, laughter, or changes in tone that might be relevant for analysis. This transcription process and data cleaning required up to 5 hours per interview, depending on audio quality and conversation complexity. The researcher also took time to triangulate the recorded data with the field notes captured as part of the interview process. After the initial correction, the transcripts were reviewed again while listening to recordings to catch any remaining errors or omissions. Attention was paid to ensuring accurate representation of participants' voices, especially when they expressed ideas in Kiswahili and *Dholuo*.

### **3.5.4 Data analysis**

Qualitative data analysis is defined as the process of sorting, coding and amalgamating data with a view to establishing patterns (Busetto et al. 2020). This study adopted a thematic data analysis approach in line with an interpretivist paradigm and well-suited with the reproductive justice theoretical framework. Thematic analysis is termed as the process of identification, analysis and generation of themes emanating from in-depth interviews with the participants (Byrne 2022). This approach was relevant in this study due to its flexibility, and it aided with making meaning of how CSOs engaged with adolescent sexual reproductive health through the rich and extensive dataset generated from the interviews.

Reproductive justice theory served as a conceptual framework and an analytical tool throughout the data analysis. It provided a frame for interpreting CSO programming experiences by identifying patterns in their programming approaches. Its core tenets, namely, intersectionality and power structures ensured that interpretation of data moved beyond individual level interventions to examining systemic factors that influenced adolescent girls' reproductive justice. From an intersectionality perspective, the data analysis examined how multiple factors influenced adolescent girls' SRH experiences and CSO programmed interventions. For the researcher to develop themes that supported with development of core research findings, a coding process was designed based on the reproductive justice theory (Brailas, Tragou & Papachristopoulos 2023). The analysis of data followed Creswell's model for qualitative data analysis as illustrated below (Bingham 2023).

**Figure 3.1: A Model For Qualitative Data Analysis**



**Source:** (Creswell & Poth 2018)

### 3.5.4.1 The coding process

The first step in the data analysis process was coding which is described as the initial step in organising information post data collection; this process entailed capturing of words and sentences as the researcher reviewed the transcribed data (Smith & Noble 2014). Coding was conducted at multi levels; the first level focused on sorting the data and assigning them labels, while the second one entailed coding using *a priori* topic codes aligned to the study's research questions and from separating non-aligned data sets. The data analysis started with a deductive coding approach since the reproductive justice theory was used as an analytical tool (Bingham 2023: 2).

Codes were developed around identity markers, such as age, gender and ethnicity with a view to analysing how they shaped adolescent girls' SRH experiences. At the same time, institutional aspects like schools, healthcare systems and religious organisations were coded and analysed to gauge whether they promoted or impeded adolescent girls' right to SRH from CSOs' perspectives. In recognition that power structures influenced adolescent girls SRH experiences and CSO interventions, codes were developed around socio-cultural, economic, political and legal structures. During the third level of the coding process, the researcher inductively analysed data under each topic code, within and across different topic codes. This step was useful in identifying emergent topics that would later be keyed as themes or findings. The fourth level focused on collapsing the inductive and deductive codes by finding common themes that were built out into findings discussed in Chapter 5.

An important consideration in this study was that the purposefully selected research participants acted as representatives of what they understood to be their "societal arenas" or organisational contexts with particular social relations in respect to adolescent girls as their core constituency, communities, funders and the government. Mostly, such "organisational repertoire-related" understandings informed the conversations, although, as demonstrated through direct quotations in the next chapter, some opinions were clearly closer to the research participants' own subjective positionings. Allowing for this fluidity (between organisational actors and private individuals) to emerge is fundamental to an intersectional approach (Vardeman-Winter et al. 2013). Moreover, an intersectional lens allowed the researcher to triangulate the findings to broader institutional heteronormativity within the healthcare system and the rigid socio-cultural scripts it produces. For instance, these scripts are glaring in the way adolescent pregnancy is framed and communicates as a population control problem to be managed and why ASRH education stops at menstrual hygiene education and management.

### 3.6 TRUSTWORTHINESS, RIGOR AND REFLEXIVITY

This study adopted Lincoln and Guba's four-dimension criteria (FDC) for establishing trustworthiness in qualitative research, namely, credibility, transferability, dependability and confirmability (Forero et al. 2018). Credibility was achieved through triangulation which Stahl and King (2020: 26) describe "*as using several sources of information or procedures from the field to repeatedly establish identifiable patterns*". The study employed data source triangulation by cross-referencing semi-structured interview data with external digital platforms to enhance the credibility of the findings (Denzin & Lincoln 2018; Noble & Heale 2025). Firstly, the researcher reviewed the websites of the participating organizations to learn more about their adolescent SRH work as well as their broader mission and mandate. A review of selected organizations' websites showed that they implemented diverse projects under different thematic areas, not just SRH. Moreover, it was evident that CSOs' programmatic shifts were linked to decreasing donor funding.

Secondly, the researcher reviewed named donor and partner websites to verify and learn more about the participants' projects. For instance, an examination of three partner organizations' websites confirmed the funding hierarchies connecting the study participants, intermediary partners and the principal donors. Finally, the study included a review of the participants' social media pages specifically Facebook and Twitter (now X), which provided public-facing content regarding their work and community engagement. Observably, most of the participants shared project information through their social media channels, the information gathered confirmed what had been identified as programming strategy and challenges. In some instances, adolescent girls' perspectives were shared via social media even though this study unit focused on CSOs. The researcher identified convergence across different platforms, thereby moderating individual participant bias and guaranteeing a comprehensive understanding of their programming strategies, challenges and opportunities (Bans-Akutey &

Tiimub 2021). In line with Onwuegbuzie & Johnson (2006) this triangulation technique enabled the researcher to not only validate findings but also uncover nuances particularly areas of convergence and divergence.

Trustworthiness was achieved through transferability, which sought to demonstrate that the research process was applicable to other contexts. To this end, the study adopted a purposive sampling approach where participants were identified against the inclusion criteria outlined in section 3.5.1. This ensured that data collected from the participants corresponded to the research objectives and questions. In addition, the researcher collected thick data via the in-depth interviews and provided thick descriptions of the research process, context and outcomes (Kakar, Rasheed, Rashid & Akhter 2023). To guarantee dependability, the researcher combined the use of primary data collection through in-depth interviews and review of literature, particularly government policies, human rights' frameworks, and grey literature from international organisations and civil society organisations (Smith & Noble 2014). Furthermore, a systematic audit trail was maintained during the research process, this included the initial semi-structured interview guide, complete transcripts of all seventeen interviews, the theme codebook detailing code definitions and their development, systematic memoranda generated throughout thematic analysis, and the researcher's reflexive notebook. Collectively, these materials formed a reliability record that chronicled both the data obtained and the interpretive decisions taken at each phase of analysis (Ahmad & Wilkins 2024).

The audit trail was accessible to the research supervisor, who acted as an inquiry auditor by periodically examining the analytical record to evaluate the consistency of the coding process and emerging themes with the data and the study's epistemological commitments (Kakar et al. 2023). The semi-structured interview protocol was uniformly implemented across all seventeen CSO participants, establishing consistency in the data gathering method. When participants introduced unanticipated topics, these were recorded in the reflexive journal as analytical deviations and regarded as valuable data instead of procedural

inconsistencies an approach aligned with the interpretive paradigm's acknowledgment that meaning is emergent rather than static (Korstjens & Moser 2018). The integration of a documented audit trail and supervisory evaluation established a robust basis of reliability for the study.

Confirmability refers to the extent to which the study findings were rooted in the data generated and not the researchers bias and preconceived notions (Lincoln & Guba 1985). Mindful that confirmability does not abolish a researcher's subjectivity based on the study's interpretive paradigm, the researcher maintained a reflexive journal that was used as a positionality tool helping the researcher keep in mind the biases that came from their work in the CSO sector (Adler 2022). Second, the detailed depiction of verbatim participant narratives in the findings chapter served as a technique for confirmability. The study offers readers adequate primary information to assess the validity of interpretations by juxtaposing participants' own words with the researcher's analytical assertions (Olmos-Vega et al. 2023). Following Sandelowski (1994), long participant extracts are not a stylistic choice in this study but a methodological one, allowing the reader to serve as a secondary auditor of the analysis's confirmability

Trustworthiness in qualitative research is intrinsically linked to ethical practices since reliable research cannot be achieved without paying attention to participant rights and research integrity (Sotto - Santiago et al. 2025). The political and cultural sensitivities surrounding adolescent sexuality in Kenya required that ethical considerations go beyond standard research protocols to encompass protection of both individual participants and the organisations they represented. As such, ethical adherence was not just a procedural requirement but a fundamental component of producing trustworthy and credible research outcomes.

### **3.6.1 Researcher positionality through reflexivity**

Olmos-Vega et al. (2023: 242) define reflexivity as a “*set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes*”. In recognition of the sensitive nature of adolescent reproductive health and the researchers positioning within the CSO sector, management of reflexivity was essential for generating credible and trustworthy findings. The reflexivity management process is articulated in the sections below.

### **3.6.2 Researcher positionality**

The researcher had built her career and professional experience in the CSO sector for over 15 years, and this brought advantages and potential biases in the research. Familiarity with the CSO sector was instrumental for appropriate participant recruitment as the researcher had knowledge of organisations working in that space and could produce relevant information. At the same time, the researcher was exposed to CSO operations’ dynamics and debates around SRH programming in general. This insider knowledge influenced her assumptions around programming choices and implementation modalities. One of the assumptions that the researcher held prior to the data collection phase was that most CSOs’ programming on SRH were predominantly controlled by international CSOs. This bias was influenced by the researcher’s experience of working in international CSOs and getting used to the idea that they are the major players in that ecosystem. This bias was reneged by the systematic participant recruitment process which made it apparent that most CSOs were local and that most of the programming was not donor funded. By leaving herself open to discovering this during fieldwork, the researcher could bracket her own bias about the major players in SRH.

Another assumption held by the researcher was that most programming activities would be oriented towards provision of SRH services to adolescent girls. This unconscious bias was influenced by the researchers' experience with donor-funded SRH projects that were mostly focused on service provision in and out of health facilities. Through the in-depth interviews, it was revealed that CSOs covered a broad range of activities including budget advocacy and community mobilisation. Revisiting the major tenets of reproductive justice as a theoretical and analytical framework before and after each day of fieldwork helped the researcher to reflect on these matters. These assumptions indicated that the researcher's professional background had been conceptually confined to neoliberal perspectives with minimal appreciation of a social justice lens.

### **3.6.3 Reflexive practices during data collection**

The researcher applied reflexivity during data collection by noting critical reflection points at the end of each interview session by writing notes in a research journal. One of the critical reflection points was CSOs intentionality about SRH programming, with or without donor funding. The study participants shared in-depth details on how they deployed personal resources to implement activities in resource-constrained environments. Their submissions corrected the researcher's bias that CSOs at the local level were largely motivated and sustained by donor funding. The dedication portrayed by CSOs reaffirmed the centrality and consistency of local CSOs in advancing social change compared to their international counterparts who exit when funding resources diminish.

In addition, the researcher did not anticipate having a discussion on sexual minorities as a target group within the larger adolescent sexual reproductive health rights programming. The researcher assumed that sexual minorities were not a target for programming in a rural set-up due to possible sociocultural backlash. The study focused on adolescent pregnancy as a reproductive justice issue, exploring how CSOs responded to the needs of adolescent girls before and after pregnancy. The discussions affirmed that CSOs addressed adolescent

SRH issues with all its diversity and not just focused on matters related to maternal health. This emergent issue motivated the researcher to probe the issue further with subsequent participants, to the extent that they were open and comfortable to discuss it.

#### **3.6.4 Power dynamics and mitigation strategies**

The researcher's position as a PHD student from a South African university created potential power imbalances with local CSO staff and this required calculated manoeuvre. It was recognised that the participants would feel compelled to provide academic answers or CSO-sector dogma as opposed to their lived experiences. To mitigate the risk of the participants' responses being performative, the researcher steered conversations towards granular and process-based inquiries instead of focusing on CSO speak. For instance, when CSOs shared their perspectives on barriers to reproductive justice in their area of work, they shared responses such as, lack of political will. In turn, the researcher would pose granular questions like, how does that look like in your experience? Or how did lack of political will present itself in your programming? Further, the researcher was adamant on knowledge co-creation from the experiences of the CSOs, as such, positioned herself as a learner and not an expert. To do this, the researcher consciously built rapport (trust) throughout the interview process, opening conversations with areas of mutual interest based on contextual realities. Strategies that helped with rapport-building, included shared experiences of motherhood with female participants, conversations on the country's political trajectory and the struggles that women had to endure to make it in life, professionally and personally. The researcher was conscious that these 'equalizing' tactics carried risks of over-familiarity that were likely to compromise professional boundaries, hence, caution was taken to prevent this. The researcher offered to share the study findings with the participants as well as sharing the final PHD thesis after examination.

### **3.6.5 Reflexivity and data analysis**

Reflexivity influenced how the researcher conducted the data analysis and interpretation. Reflexive approaches were applied during coding, theme development and writing of research findings. As highlighted above, the researcher held assumptions that CSOs would be focused on service delivery, however, reflexive notes from the interviews showed that CSOs engaged in more social-justice engagements. To manage these assumptions, deductive codes were developed based on the reproductive justice theory, which broadened the scope for data analysis and interpretation. Specifically, the tenets of intersectionality and power analysis were applied in the generation of themes and accompanying quotations supporting the findings discussed in Chapter 4.

## **3.7 ETHICAL CONSIDERATIONS**

This study navigated ethical intricacies essential in researching adolescent sexual reproductive health within Kenya's socio-cultural and political context. The research involved civil society organisations working on politically and socially contentious topics. Ethical considerations in this study involved compliances with research protocols and the embedding of research ethics and values along with the research processes (Carpenter 2017). Ethical approval was obtained from the University of South Africa (UNISA) Ethics Review Committee prior to the data collection process under the reference number *53315669\_CRECHS\_2022* (Annexure A). Additionally, a research permit was secured from the National Commission for Science, Technology and Innovation (NACOSTI), licence number *NACOSTI/P/22/20480* in Kenya, ensuring compliance with national research regulations (see Annexure B).

### **3.7.1 Informed consent and voluntary participation**

The researcher ensured that informed consent was sought from the study participants. This was done at different levels; at the recruitment stage, where

they were verbally introduced to the objectives of the study by sharing the participant information sheet (Annexure C) and consent form (Annexure D). Only participants who indicated their willingness to engage in the study received formal invitations via email. Given that participants in this study were representing their organisations, only senior leaders and their official designates were engaged. At the same time, consent to participate in the study and recording of the interview proceedings were done before the actual interview; none of the research participants withdrew from the process at the interview stage. In some instances, participants requested a copy of the recording for their own use, which the researcher made available.

### **3.7.2 Confidentiality and privacy**

Adolescent sexual reproductive health is a sensitive subject matter even for CSOs that implement programmes. Often, matters related to SRH are equated to abortion and CSE, which may negatively impact an organisation's standing with the communities and government officials. In the process of data collection, it emerged that some participants implemented programmes that promoted the rights of sexual minorities, thereby, requiring anonymity. As such, all participants were given pseudonyms, and no personal identifiers were used in the process of data collection and reporting.

### **3.7.3 Data storage and security**

Data storage and security were adhered to in this study to ensure confidentiality and anonymity of study participants and the information they shared. Given that the interviews were conducted virtually, data security and protection were inherent, in line with UNISA data protection policy as discussed in Section 3.5.3.6.

### 3.8 METHODOLOGICAL CONTRIBUTION

This study makes a methodological contribution through how it deployed reproductive justice as a theoretical framework in the research process. Specifically, the decisions made about sampling, data collection, and analysis that extend established methodological practices in ways that are transferable to future research. The first methodological contribution is the operationalisation of reproductive justice theory as an active analytical instrument in thematic coding, rather than as a post-hoc interpretive frame applied only in discussion (Herber, Taylor & Bradbury-Jones 2026). In most qualitative studies, theoretical frameworks are introduced in literature reviews and revisited only when interpreting findings. In this study, the three rights under reproductive justice, were embedded directly into the deductive coding framework used in the first stage of thematic analysis. This integration meant that the theory did not merely describe findings retrospectively; it structured the researcher's interrogation of the data at the point of analysis, enabling the study to move beyond a descriptive account of what CSOs do, towards an analytical account of how their programming engages, advances, or inadvertently forecloses adolescent girls' reproductive rights (Morison 2021; Ross 2020). This operationalisation of theory-as an analytical tool is replicable and offers a practical template for qualitative researchers seeking to apply rights-based frameworks to CSO and reproductive health research in African development contexts.

The second methodological contribution was related to the sample size determination. This study applied Malterud et al.'s (2016) information power framework to justify a purposive sample of seventeen CSO leaders ; a framework originally developed in health research contexts where individual patients and community members constituted the unit of analysis. This study demonstrated that the information power framework transferred productively to research with institutional actors. When participants are organisational rather than individual,

the depth and specificity of each participant's institutional knowledge encompassing programmatic strategy, funding relationships, policy engagement, and community implementation can substitute for the numerical breadth conventionally associated with rigorous qualitative sampling.

Provided the study's scope is precisely delimited, the theoretical framework is actively deployed throughout analysis, and data saturation is systematically monitored, a small sample of purposively selected CSO leaders generates sufficient information power to sustain analytically rigorous thematic analysis. This application of the information power framework to organisational participants has not been previously documented in the reproductive health CSO literature and offers a replicable sampling rationale for institutional case study research in similar contexts (Malterud et al. 2016).

Together, these two methodological innovations, the embedding of reproductive justice theory's constructs as active analytical tools in coding, and the extension of the information power framework to organisational participants added a distinct methodological dimension to this study's contribution, one that is separable from its empirical findings and its theoretical positioning, and one that can inform the design of future qualitative studies of civil society and reproductive justice in sub-Saharan Africa.

### **3.9 CONCLUSION**

This study was based on an interpretivist paradigm utilising a qualitative research design that was relevant for exploring the multifaceted realities of ASRH programming by civil society organisations in a rural context. The choice of Siaya County as a case study provided suitable context for understanding how CSOs implemented activities towards advancing adolescent girls SRH needs as they navigated sociocultural, political and organisational dynamics, in specialised settings. The study participants were purposively sampled based on inclusion criteria set out at the beginning of the research process. Overall, seventeen

diverse CSOs were interviewed presenting a broad range of organisational mandates, programming approaches and contextual realities that influenced the promotion of adolescent reproductive justice. A small sample size was preferred in this study guided by Malterud et al.'s (2016) information power framework on how to determine sample size; data saturation was achieved through quality, rather than quantity of participants.

The research questions required intensive conversations, hence the choice to use in-depth interviews as the main data collection method. This allowed for exhaustive exploration of the nuances that could not be quantified or hypothetically pre-determined. These interviews were conducted virtually enhancing accessibility and participant expediency without compromising data quality. The study adopted a thematic data analysis approach anchored on reproductive justice theory as a conceptual framework and analytical tool. The data analysis process incorporated intersectional perspectives in identifying patterns and themes enabling a broad perspective on how different factors shaped adolescent SRH experiences and CSO programmes and strategies.

To ensure methodological rigor, reflexivity was managed throughout the research process, the researcher's assumptions and biases based on her positioning within the CSO sector were explored and managed. The interpretive paradigm adopted in this study enabled the creation of knowledge based on subjective CSOs programming experiences. This resulted in an expanded application of reproductive justice as a theoretical and analytical framework, within a rural context. This process demonstrated that when a qualitative case study methodology is rigorously applied, valuable insights into complex social phenomena can be achieved, while respecting participant dignity and organisational contexts.

The subsequent chapter provides comprehensive details on the civil society organisations interviewed and the findings based on data analysis and interpretation.



## **CHAPTER FOUR: RESULTS AND FINDINGS**

### **4.1 INTRODUCTION**

This chapter presents findings derived from the in-depth interviews conducted with seventeen purposefully selected civil society organisations, implementing activities on adolescent sexual and reproductive health rights in Siaya County. The significance of this study was articulated in Chapter One (see 1.3, in particular), where the staid notions of adolescent pregnancy as an outcome of personal choices that are removed from their socioeconomic and cultural environments, were countered. Specifically, this study interrogated civil society organisations' relevance in driving a progressive and full adolescent sexual reproductive health agenda, based on the reproductive justice theory discussed in Chapter Two (see 2.5, in particular).

Key tenets of the reproductive justice theory include a holistic notion of interconnected human rights that include sexual freedom, reproductive autonomy and bodily self-determination (Morison 2023). The justice component of reproductive justice theory assesses SRH beyond the individual level, with a view to addressing structural barriers to the right to SRH (Morison 2021). Overall, reproductive justice focuses on the following - the right to have children, the right not to have children via birth control, abortion and abstinence, and the right to have children in safe and healthy environments (Beck et al. 2024). Further, this study sought to problematise the concept of individual choices, recognising that multiple and intersecting factors influence girls' agency and bodily autonomy. These perspectives were deployed in the framing of the interview questions, generation of themes, interpretation and presentation of the key findings.

The results in this chapter are presented in a distinct format. Firstly, background information about the study participants is given to explain the context. Secondly, a summary of themes generated from the data analysis is given and discussed.

The following Chapter Five will discuss the conclusions and recommendations from the study.

## **4.2 BACKGROUND INFORMATION ON THE STUDY PARTICIPANTS**

The researcher gathered information about the study participants' backgrounds by asking questions about their organisations' registration and programme mandates, specifically, the types of development interventions they deliver and their funding modalities.

### **4.2.1 Registration status of the organisations**

Participants in this study comprised 17 civil society organisations purposively selected based on the inclusion criteria outlined in Chapter Three (3.2.1, in particular). The study participants were registered by the Government of Kenya under different legislative frameworks; eight were registered under the Companies' Act 2022 as Companies Limited by Guarantee (CLG) and the NGO Coordination Act 1990. The purport of registering CSOs as CLGs was to give them a legal persona and allow them to work nationally, pursuing broad non-profit objectives. The other nine participants were CBOs registered with the Ministry of Labour and Social Protection under the Directorate of Social Protection with a restricted geographic mandate to address the social causes of poor ASHR outcomes at specified Sub - County levels.

Table 4.1 below provides a breakdown of the registration types of the CSOs interviewed and their geographic areas of focus in Siaya County, as at the time of the interviews.

**TABLE 4.1 REGISTRATION STATUS OF THE CSOS AND NGOS IN THE SAMPLE**

<b>TYPE OF REGISTRATION</b>	<b>GEOGRAPHIC FOCUS (SUB-COUNTIES)</b>	<b>NUMBER</b>
<b>CBOs</b>	Alego Usonga	2
	Alego Usonga and Bondo	1
	Bondo	3
	Bondo and Rarieda	1
	Ugenya	1
	Ugunja, Ugenya and Alego Usonga	1
<b>NGOs</b>	Alego Usonga	1
	Alego Usonga, Bondo, Ugunja, Gem	1
	All Sub-Counties	3
	Bondo and Rarieda	1
	Bondo Sub - County	1
	Ugenya, Gem and Rarieda	1
<b>TOTAL</b>		<b>17</b>

Source: Researcher's field notes

#### **4.2.2 Mandate of the organisations**

The researcher sought to understand the organisational mandates by asking about the type of development interventions they implemented in general and around SRH specifically. The interviews revealed that all the civil society organisations were engaged in multiple development interventions at the community and county levels. The study revealed that the CSOs executed integrated development initiatives across various thematic domains, including economic empowerment, human rights advocacy and governance, environmental protection and climate change, education and skill training, and sexual and reproductive health. This finding aligns with that of Hilton (2018), who posited that the role of CSOs is *ad hoc*, expansive and misinterpreted, making it

challenging to identify their impact in poverty-reduction and development, which are their core mandates.

Narrowing down to sexual and reproductive health programming for adolescent girls, the study found that the organisations' project activities were mostly domiciled under the SRH, human rights advocacy and governance thematic areas. This distinction was critical because the reproductive justice theory emphasises all human rights whilst addressing immediate and systemic barriers to SRH rights and acknowledging the role of intersecting issues that influence adolescent girls' sexual and reproductive health (Beck et al. 2024). This holistic stance is essential because SRH programmes and policies often take a purely risk-focused approach and target individual girls and women, with limited focus on the justice elements (Morison & Herbert 2018). A programmatic focus on health advocacy and governance aligns with African feminist thought which recognises that women and adolescent girls' socio-economic outcomes cannot be separated from politics and political processes (Mama 2020). By placing adolescent sexual reproductive health and rights activities in the broader advocacy thematic areas, a risk-only focus can be avoided. Participants' programming interventions are discussed in detail in Section 4.3.1, where a blend of activities is discussed comprehensively.

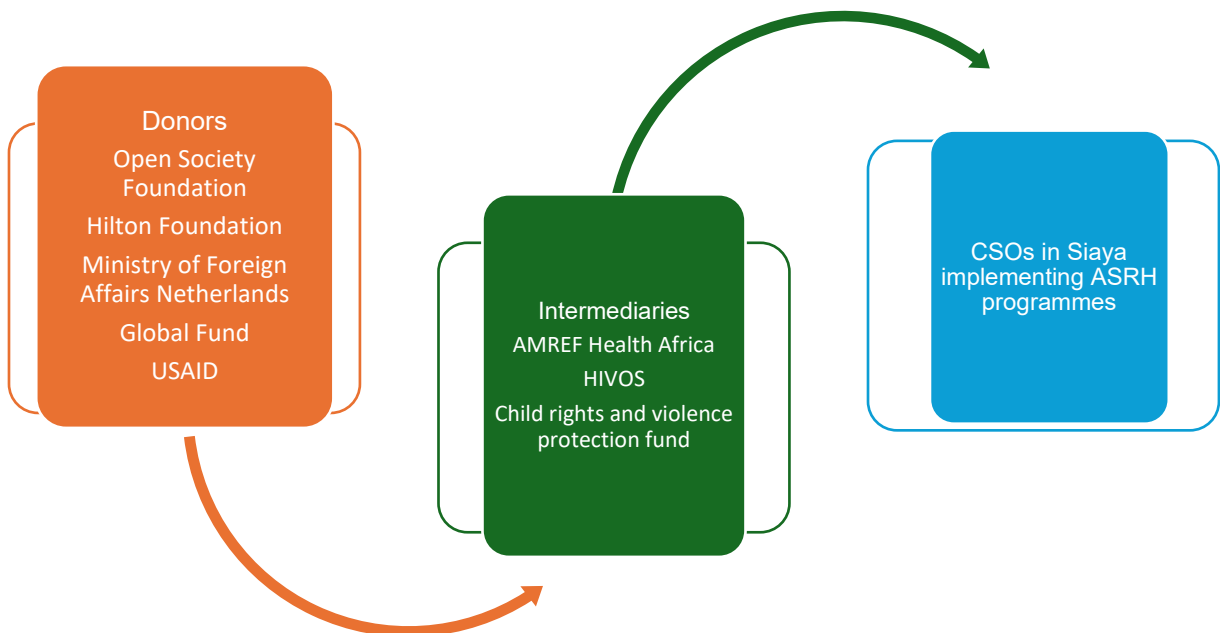
#### **4.2.3 Funding for project activities**

As part of unearthing the participants' mandate, the researcher sought to understand how SRH activities targeting adolescent girls, were funded. It emerged that SRH activities were funded in three ways. Firstly, donor funding over a specified project period; secondly, short-term partnerships with other CSOs; and thirdly, through voluntary efforts by members of the organisation.

Regarding donor-funded adolescent SRH activities, it emerged that CSOs accessed funding through projects' consortia. Under this arrangement, projects supported by a single donor were carried out, with several groups contributing to

shared project goals and outcomes and all partners drawing money from a single budget. The consortium model is centred around a hierarchical organisation structure in which all study participants were sub-grantees of international civil society organisations that had contractual connections with the principal donors (Ajuwon et al. 2022). Figure 4.1 offers a breakdown of the consortium relationship, as described by the study participants:

**FIGURE 4.1: Relationship Between Consortium Partners**



Source: Researcher's field notes

The figure above outlines the relationship and hierarchy in donor-funded projects at the time of the study. Principal donors are at the top of the hierarchy, and their role is to predominantly provide funding to projects in the consortium leads, as shown in the second tier. The consortium leads outlined in the second-tier sub-

granted funding to the civil society organisations, outlined at the bottom of the hierarchy. None of the study participants were primary consortium partners, instead, they were sub-grantees to international NGOs that held contractual agreements with the main donors and who sub-granted a portion of the main funding to conduct project activities. Proponents of consortia models argue that they are catalytic for the following reasons: shared technical skillsets by leveraging on the partners expertise and delivery of impact at scale (Finkle et al. 2024; Strasser et al. 2021). With regards to the study participants placement in consortia structure, Ngumbela and Mle (2019), posit that sub-granting relationships between local CSOs and international ones are considered a necessary evil. It is assumed that CSOs in the Global South have stronger constituencies as well as social and political legitimacy based on an assumption that they have sound understanding of the context because they frequently interact with communities.

From a critical feminist standpoint, consortia management models exemplify neoliberal development ideologies more so, technocratization where complex social issues like adolescent SRH are minimised to technical issues with clear logical solutions and change timelines. Through consortia, managerialism is practiced as evidenced in management of people, results and budgets in a hierarchical manner (Gatenby 2024). These ideologies lead to constrained agency due to stringent donor expectations and bureaucratic processes as well as limited opportunities for local voices in donor driven processes (Kagwe et al. 2023).

When discussing the funding hierarchy of donor-funded SRH projects with the study participants, conversations always turned to the problematisation of the international aid architecture as it relates to ASRH services. A reproductive justice lens is critical in interrogating the power structures within the aid continuum, as these influence funding flows and CSOs' capacity to address the needs of their constituencies, in relevant ways (Matheka & Nzomo 2023). International CSOs are intermediaries and a conduit through which funding passes when working

with local CSOs. These global CSOs have mandates over resource mobilisation, global advocacy and donor compliance. Studies have found that these hierarchical arrangements preserve power imbalances between local and international CSOs (Décobert & Wells 2025; Ferati et al. 2023).

Overall, in as much as donor funding was an enabler of Adolescent SRH programming, CSOs had to co-exist with , and navigate neoliberal realities that were often anti thesis of their social justice values and mission.

Turning now to the type of project activities supported through donor-funded projects, this study found that two types of activities were predominant. First, awareness creation on SRH issues, as outlined in the first and second quotations, and secondly, capacity-strengthening for advocacy, as shown in the third quotation.

*“Through the same project we had other spaces where we engaged with teen moms by mostly creating awareness on issues of comprehensive sexual and reproductive health education. On the celebration of World Menstrual Hygiene Day, we engaged about a hundred teen moms to create awareness of issues of menstrual hygiene.” **Interview with CSO 17***

*“So, at the Youth Wellness Centre, what we have been able to do uniquely is to have recreational activities. All these activities are meant to bring the young people together.” **Interview with CSO 5***

*“There is a whole lot of work around capacity building because it aims at strengthening the capacity of young people to be able to engage in advocacy processes at county, national, and even regional or international levels, and that comes with multiple*

*topics like understanding what advocacy is and how to prepare for advocacy.” Interview with CSO 9*

The second category of participants implemented SRH activities with financial support from short-term partnerships with other civil society organisations within the county. This set of CSOs were involved in activities, such as distribution of sanitary towels and community sensitisation on menstrual health and hygiene. The quotations below illustrate participants’ sentiments on such engagements:

*“We still don’t have a donor partner, but we have a few strategic partners – those who come and help us implement a three-month project.” Interview with CSO 13*

*“We do community sensitisation in partnership with an organisation called Centre for Solidarity and Justice. We train, and we do advocacy around issues. For example, gender-based violence and personal hygiene, and then we are also doing issues around economic empowerment.” Interview with CSO 4*

The third category of participants were those without donor funding, but who were able to mobilise resources internally by securing volunteers to contribute their time or to provide financial support. The quotation below illustrates how CSOs mobilised resources to implement SRH activities in their areas of intervention.

*“Currently, our organisation does not have funding. We have members, so when we have activities that we want to implement, usually members come on board and say, hey, I can be resourceful here.” Interview with CSO 4*

Activities implemented through volunteers or member support included mobilisation and supply of sanitary pads and awareness creation on SRH, via mentorship, as illustrated below:

*“One thing that we’ve gained through our partnerships and one of the models that we use as an organisation is that we have some sort of sustainability mechanism that enables our activities to go on somehow, even without major funding. For example, the mentors that we have trained exist within the organisation, and now, we integrate our projects in such a way that we keep projects going and involve these mentors” Interview with CSO*

**7**

These preceding paragraphs give vivid descriptions of the types and sources of funding facilitating the implementation of SRH programmes, among the study participants. There were no fundamental disparities in the types of activities implemented by the participants, based on their respective funding sources. Instead, the length of the funding tended to determine the time frames and scales of the activities. The participants indicated that agreed contractual requirements with donors largely influenced their ability to access funding and the types of projects they implemented. These activities and their funding are discussed in greater detail further on in this chapter.

The foregoing section has provided a background of the study participants, outlining their registration status, the type of programming they were involved in and the funding modalities for project activities focusing on sexual and reproductive health. The next section discusses the themes that emerged from the interviews with CSOs, around their engagements with adolescent SRH programmes.

### **4.3 THEMES EXTRACTED DURING DATA ANALYSIS**

The data analysis process was discussed in Section 3.5 and coding process discussed under Section 3.5.4.1. In developing a framework of themes, the researcher considered the following aspects:

1. Mapping out, from the insights of the research participants, those structural, financial, cultural, global, institutional and gender issues that influenced CSOs' ASRH programme interventions.
2. Talking to the research participants about their views of the effectiveness of the strategies deployed by CSOs regarding ASRH programming.
3. Understanding the research participants' perceptions, experiences and understanding of the ways in which politics, socioeconomic and sociocultural factors, policies and laws on CSO engagement with ASRH, shape the CSOs' activities.
4. Sharing insights on policy recommendations from the participants as people working at the coalface for the realisation of adolescent girls' reproductive justice in Kenya.

Four major themes emerged as laid out in Table 4.2 below.

**TABLE 4.2: SUMMARY OF THEMES EMERGING FROM DATA COLLECTION**

<b>THEME</b>	<b>SUBTHEME</b>
<b>Theme 1: Programme interventions on adolescent sexual reproductive health rights</b>	<ol style="list-style-type: none"> <li>1. Adolescent girls' participation</li> <li>2. Menstrual health and hygiene</li> <li>3. Prevention and response to gender-based violence</li> <li>4. Community outreach and advocacy</li> </ol>
<b>Theme 2: Barriers to reproductive justice for adolescent girls</b>	<ol style="list-style-type: none"> <li>1. Sociocultural perspectives on sexual reproductive health</li> <li>2. Politics of comprehensive sexuality education</li> <li>3. Gender dynamics and power relations</li> <li>4. Limited access to contraceptives and SRH services</li> </ol>

THEME	SUBTHEME
<b>Theme 3: Challenges around the implementation of policies and laws on adolescent sexual reproductive health</b>	<ol style="list-style-type: none"> <li>1. Low political commitment and leadership</li> <li>2. Devolution of national policies at the county level</li> </ol>
<b>Theme 4: Challenges faced by civil society organisations in the deployment of their mandate</b>	<ol style="list-style-type: none"> <li>1. Legal restrictions</li> <li>2. Funding</li> <li>3. Competition among CSOs and duplication</li> </ol>

Source: Researcher's field notes

#### **4.4 EVALUATING CIVIL SOCIETY ORGANISATIONS' PROGRAMMATIC INTERVENTIONS**

One of the objectives of this study was to evaluate the effectiveness of strategies deployed by CSOs on ASRH programming in Siaya County, from a reproductive justice lens. Assessing effectiveness included ascertaining the research participants' understanding of this term - effectiveness as goal achievement – hence necessitating actual results in societal transformation and the nature and extent of adolescent girls' involvement beyond tokenism in their programmes. This was achieved by interrogating the type of programme interventions that were implemented, and four sub-themes emerged - adolescent girls' participation, menstrual health and hygiene, prevention and response to gender-based violence, and community outreaches and advocacy.

##### **4.4.1 Adolescent girls' participation**

Villa-Torres and Svanemyr (2015) indicate that participation is a critical element in rights-based programming where adolescents as rights' holders possess the power to identify issues that affect them, and curate solutions based on their realities. Similarly, this study found that CSOs prioritised adolescent girls'

participation in their SRH programming at different stages of their project life cycles, specifically, at project design and implementation phases. In terms of project design, most participants reported that adolescent girls were involved in ideating projects by initially participating in needs assessments and shaping the project activities, particularly for donor-funded projects. The study found a clear tension between functional participation, that is, delivering project goals through adolescent girls and transformative feminist engagement where true power was shifted to girls. According to the study participants, the involvement of adolescent girls was necessary to ensure relevance, ownership and sustainability of the project interventions and outcomes as illustrated below:

*“The programme is unique in that, within the first phase, it involved matters of learning from the girls. And engaging the stakeholders both at the local level and at higher levels. So, it is the issues, the recommendations, and the feedback that we got from the stakeholders and the girls that we, as clusters, came and analysed and evaluated to give guidance to what we do.”*

***Interview with CSO 17***

Another participant indicated:

*“We engage our young people to get their ideas on what they envision at the Youth Wellness Centre. So, it is something that we don’t do as staff or as an organisation as a top-down intervention; instead, we engage our young people and get opinions from them.”* ***Interview with CSO 5***

Adolescent girls’ participation at project design was more apparent in donor-funded projects, as this was part of the larger programme design guidance from the donors. This finding is concurrent with Iye and Akinpitan (2023), who noted that donors largely influence programme designs. In addition, the participants indicated that adolescent girls participated in project implementation for both

donor-funded and non-donor-funded projects as volunteers, trainers, and facilitators of community-level advocacy, such as commemorating major calendar events, awareness-raising sessions and training, as outlined below:

*“it’s the boda [bicycle] girls who go to primary schools and teach the girls about menstrual hygiene because they are already taught about menstrual hygiene.”* **Interview with CSO 6**

*“We do mentorship programmes monthly. We have some capacity-building workshops, so the girls always attend... Then they come back and teach other women who never attended those workshops so that they can all have the knowledge.”*  
**Interview with CSO 2**

The meaningful participation of young people in sexual and reproductive health programmes has been emphasised not only as a political and social right, but also as a mechanism for ensuring relevance and effectiveness of programmes. This perspective is aligned with the human rights’ tenets of reproductive justice theory, especially equality, non-discrimination and participation, which are crucial to SRH for adolescent girls (Broberg & Sano 2018). The impact of meaningful participation of adolescents in youth programming is measured through impact and process indicators. One of the indicators is a measure of the SRH impact accomplished through adolescents’ engagement in policymaking or programme execution. The second indicator assesses the degree to which adolescents and young people participated meaningfully (Villa-Torres & Svanemyr 2015).

An African feminist perspective to adolescent participation in development interventions indicates that young people are treated as objects to be measured based on the use of language such as indicators and efficiency. Furthermore, feminists like Mama (2020) demonstrate that CSOs are entrapped in the global neoliberal health programming dogma that reduces them to service providers. Consequently, CSOs reproduce top-down colonial style programme approaches

with limited and no appreciation of African contextual realities (Mama 2007). Given that adolescent participation was an established program design prerequisite by the donors, it goes without saying that the CSOs had to be prescriptive in their approach to meet the donor standards.

The study participants introduced a new dimension to adolescent participation that was not captured by the literature review, namely the involvement of adolescent girls as volunteers during periods when the organisation was understaffed, to alleviate staffing pressures, as explained below:

*“We are only two employed workers. There are young women who can come in case we have a certain activity or a meeting... they go and represent the organisation. And, during our outreach, they come in; they help in one, two, or a maximum of three activities. And also, the international meetings, if any of them has a passport, they’ll always attend.”* **Interview with CSO 2**

What is critical to note is that when the adolescent girls volunteered their time and services, no remuneration was involved since the organisations did not have funding. This type of engagement raises economic justice issues; feminist thought frames this gendered labour exploitation where adolescent girls deliver services without pay (Womankind Worldwide 2021). Additionally, intersectional issues on documentation and class emerge where adolescent girls with travel documentation could represent the organisation in international meetings which is contrary to the aspirations of meaningful participation (UNICEF 2022). Legally speaking, remunerating adolescents for work done would be tantamount to child labour. What this study has highlighted is that adolescent participation in project implementation was used as a coping mechanism for CSOs facing funding and human resource constraints. Studies have shown that small CSOs face operational challenges, including financial unsustainability, which impact their staffing (Chanase 2023; Kermani & Reandi 2023; Erdilmen & Sosthenes 2020).

Challenges facing CSO operations are discussed in greater depth later in this chapter.

The second way in which adolescent girls were involved in the CSOs' engagements was through organisational governance, especially for those that identified as being youth-led. Of the seventeen participants interviewed, four identified as being youth-led with slots in their boards for young people. The quote below illustrates how CSOs operationalised this:

*“The two slots in our board are reserved for young people who are under 30, so at every level you have a representation of young people, and this is drawn from the volunteers that we work with.”* **Interview with CSO 9**

This finding indicates that CSOs boards are invited spaces for adolescent girls (Cornwall 2016). Whilst this is a progressive step towards inclusion, a feminist lens interrogates the extent to which adolescent volunteers can deploy their power fully in a board, where they must fit into existing governance structures (Pleson et al. 2019). In addition, the sub-theme highlighted that CSOs moved towards inclusive programming in line with broader policies on adolescents and young people's engagement, including the African Youth Charter (African Union 2009), UN Youth Strategy (United Nations 2018), and the Kenya Youth Development Policy (Republic of Kenya 2019a). However, their approaches could be framed as ‘add girls and stir’ where organisations focus on adopting a utilitarian approach to participation without addressing underlying power structures (Cornwall 2016). In this study, adolescent girls were plugged into existing systems and processes as board members and peer educators without evidence of shifting power structures. This reality made the adolescent girls’ engagement rather performative than transformative (Henze-Pedersen & Bengtsson 2024).

#### 4.4.2 Menstrual health and hygiene

Menstrual health and hygiene (MHH) programming emerged as a major adolescent SRH intervention among the study participants. From the interviews, MHH programming was deemed necessary due to adolescents' low access to sanitary pads due to their high cost; this negatively impacted their school attendance, as illustrated below.

*“The reason why we focus on menstrual hygiene at the primary school level is that when COVID hit, there was quite a big number of teen pregnancies. When schools reopened almost after a year, we helped girls as early as the age of 13 years to deliver babies. In addition, we did a survey, and it showed that girls did not want to go to school during their periods because they could not have menstrual products that were easily available.”* **Interview with CSO 6**

Secondly, because of limited access to sanitary pads, adolescent girls were vulnerable to sexual exploitation by men whom they approached for financial support. In this regard, one interviewee said:

*“Our head office is in Yimbo, which is surrounded by the beaches, and sexual exploitation is so rampant there. You can find a girl who is leaving school, and she already knows that this is the person (referring to a man) that will help her to buy essentials like sanitary towels if she offers him sexual favours.”* **Interview with CSO 12**

The study participants rationale for MHH programming was focused on three factors, exposure to sexual exploitation, high cost of sanitary pads and school absenteeism. With reference to adolescent girls' absenteeism from school,

feminist researchers contend that this claim lacks empirical evidence and is used to overshadow other aspects of menstrual health management including teacher bias and infrastructural gaps (Joshi et al. 2015). These findings align with Sommer et al. (2021); Phillips-Howard et al. (2016); Oruko et al. (2015), whose studies found that girls from impoverished backgrounds obtained money and rewards from men in exchange for sex to pay for essentials, like sanitary pads. This situation increased adolescents' vulnerability to HIV/AIDS transmission, unintended pregnancy and school dropout (Haider 2023).

To curb the challenges around access to sanitary pads and adolescents' vulnerability to sexual exploitation, the participants indicated that they programmed around two areas. One, awareness creation on MHH targeting in-school adolescent girls through school clubs, as demonstrated in the first quote below, and distribution of sanitary pads, as indicated in the second quote.

*“We have established Afya (Health) Clubs in eleven schools here in Siaya. During the Afya club sessions we engage with students on issues of menstrual hygiene, self-esteem and gender-based violence.”* **Interview with CSO 10**

*“We train them on menstrual hygiene, specifically how to take care of yourself during your menses, and also in the past we have provided sanitary towels and personal care kits.”* **Interview with CSO 4**

From the findings above, it is evident that the vulnerability of adolescent girls to sexual exploitation is exacerbated by menstruation, which is a natural occurrence and an essential element of a girl's reproductive health (UNICEF 2019). Most of the research participants focused on distribution of sanitary pads to address adolescent girls' immediate needs with no evidence of tackling systemic gaps. A reproductive justice perspective shifts focus from interventions that target an individual girl, to addressing structural issues that encumber access to SRH

rights. Even though mitigation of sexual exploitation of adolescent girls through sanitary pad distribution was necessary, this was not sustainable since a girl is left in the same destitution she was in before. The distribution of sanitary pads is part of a wider 'quick fix' product centred approach which technocratized a complex social justice issue. Authors like Bobel et al. (2020) problematise this approach indicating that CSOs target individual girls failing to address root causes of inequality hence facilitating reproductive injustice of adolescent girls. In this case, structural issues such as sexual exploitation and economic justice were not addressed, yet they intersected to expose adolescent girls to reproductive injustice.

Other studies have challenged the overemphasis on the supply of sanitary pads in MHH programmes as opposed to other system-related interventions such as infrastructural improvements and countering negative gender social norms (Babbar et al. 2022; Warrington et al. 2021). This study demonstrated that the CSO led MHH interventions perpetuate neoliberal obsession with individual girls with minimal focus on challenging systemic issues such as poverty and the affordability of sanitary products, which would offer lasting change.

Upon enquiry on the source of sanitary pads that the participants distributed, it was reported that the CSOs received supplies from other civil society actors through short-term partnerships and personal contributions at the organisational level, as discussed in section 4.2. The quote below demonstrates this:

*"We have been able to distribute some sanitary pads to the schools by partnering with Kuzania and Zana Africa. GLOBCOM and World Vision have also been able to support us with some dignity kits that enabled us to support the girls."* **Interview with CSO 11**

Specific to personal contributions at the organisational level, a participant indicated that they had to develop innovative ways to sustain the supply of sanitary pads.

*“There is something we started as an institution known as ‘pad banking’. So, we bring sanitary pads to a central store with the help of volunteers or donations. In case there is any girl that has a period but cannot afford sanitary towels.”* **Interview with CSO**

**3**

The quotations above show a short-term approach to sanitary pad distribution projects that are not sustainable, a perspective held by Sommer et al. (2021), who contended that short-term interventions are not scalable or sustainable. Critically, funding cycles and good will from well-wishers cannot outlast an adolescent girls’ 30 – 40-year menstrual cycle. Equally, sanitary pad donations whilst critical in the short term, take away an adolescent girls’ agency as she must be open to receiving anything, this reinforces donor-beneficiary hierarchy with a potential for abuse (Ilesanmi & Afolabi 2022).

In addition to addressing the need for sanitary pads, some participants indicated that programming around menstrual health and hygiene was tactfully used as an entry point for discussing other SRH-related issues such as adolescent pregnancies, as articulated below:

*“We go to high schools to give menstrual hygiene and STI information and information on HIV and AIDS and sexual and reproductive rights for both girls and boys. And at the primary school level, we give reusable sanitary towels to class eight students to enable them to stay in school and be able to complete their primary level so that we have that good transition of education from class eight to high school without recurrent*

*dropouts of young girls due to pregnancy.” Interview with CSO*

**6**

Whilst this approach appears pragmatic, post development and African feminist lenses suggest that using MHH as an entry point is a form of biopower where, a natural biological occurrence is used to propel neoliberal goals such as school completion for human capital (Potvin 2019). On the other hand, by linking distribution of sanitary pad to recurrence of school dropout due to pregnancy frames an African adolescent girl as a problem to be addressed (Gonick 2006).

Through the interviews, it emerged that study participants promoted the visibility of menstrual hygiene and health issues by commemorating major dates such as World Menstrual Day at the community level, as highlighted below:

*“On the celebration of World Menstrual Hygiene Day, we engaged about a hundred teen moms to create awareness of issues of menstrual hygiene. They call it ‘period poverty’. So, it’s more of a sensitisation and awareness forum.” Interview with CSO 17*

One participant implementing a USAID-funded Water, Sanitation and Hygiene (WASH) project indicated that they promoted innovations in MHH programming through market-based approaches. Market-based approaches refer to the integration of local markets to supply sanitation and hygiene products and services with the aim of improving the availability and quality of WASH products (Lestikow et al. 2019). The participant’s narration is shared below:

*“Then at the community level, we have a project that we are partnering with USAID, and it is focusing on market-based menstrual products at the household level. The importance of having a market-based approach is that there is a variety of*

*products that they (women and girls) can access in regard to menstrual hygiene. Interview with CSO 6*

The foregoing quotation shows that donors influence CSOs programme designs and choices in favour of integration of markets for MHH under the guise of a human rights approach. This finding is in line with Potvin (2019), who asserts that SRH programmes perpetuate neoliberal approaches by considering girls' bodies as biological sites. In this case, menstruation is a market that private businesses can build their enterprises on, thereby , adolescent girls not considered as people with the right to health , but as consumers of market products Equally, the adoption of market-based MHH interventions contradicts the very challenge that CSOs attempt to tackle, that is, accessibility due to poverty in general and gender-skewed poverty in particular. This finding exemplifies how CSOs propel neoliberal narratives and given their role in influencing social change, it can be argued that they promote 'market centric' narratives among their constituency.

The gaps discussed above occur against a good policy environment around menstrual health management , including the *Kenya Menstrual Hygiene Management Policy 2019–2030*, which focuses on breaking the silence on menstruation, safe and hygienic management of menstruation and safe disposal of used menstrual materials and products (Republic of Kenya 2019b). Among the priority actions articulated in this policy is the integration of menstrual health in county-integrated development plans (CIDP) and budgets, yet availability of sanitary pads is still low.

The outcomes around this sub-theme draw a connection between menstruation and vulnerability to sexual exploitation, unintended pregnancy and school dropping out. Providing access to sanitary pads as part of MHH is necessary, as a short-term measure but not sustainable in the longer term. This programme intervention promotes *NGOisation* of menstruation, as the CSOs take on the role of government moving away from their oversight and accountability role. These

results show that CSO interventions in this area of work fall below the social justice threshold by failing to address access barriers that exclude and marginalise adolescent girls. As indicated in Chapter 2, CSOs in Kenya are part of a post-colonial global health architecture that is highly influenced by donor logics especially individualist interventions and exploiting women's and girls' bodies for market expansion. Furthermore, African feminists caution that activities such as awareness creation displace local knowledge for instance, locally available products by framing them as backward to make way for western products (Rossouw & Ross 2021). To shift from technocratic ideologies and activities, CSOs need to situate African women and girls as rights holders not charity cases in their programmes and shift towards a re-politicised SRH agenda.

#### **4.4.3 Prevention and response to gender-based violence**

Gender-based violence (GBV) occurs within the settings of unequal power relations between men and women, and addressing it is critical to the protection of sexual and reproductive health rights of women and girls (Akudolu et al. 2023). Findings from this study show that GBV was rampant in Siaya County and that participants implemented project activities geared at protection and prevention of the same. GBV presented itself in the form of early marriage and sexual violence, particularly defilement, the sexual penetration of a child, all of which had negative outcomes such as unintended pregnancies, reproductive tract infections, STIs and HIV, an observation also made by Grose et al. (2021). Instances of unintended pregnancies for adolescent girls may result in complications, emphasising the need for abortion services in an instance where a girl chose not to have a child or access SRH services in case they chose to keep the child (Acharai et al. 2023).

The specific project activities implemented to prevent and respond to GBV were encouraging reporting and referrals, community sensitisation and advocacy.

In relation to GBV response, the participants spoke at length about reporting and referrals, where they helped survivors of violence to report cases and collaborated with service providers to help survivors access services and justice as outlined below:

*“We rescue girls who are in early marriages [referring here to the woman being of school-going age when married], and we integrate them back to school. We report cases of defilement [referring to sexual penetration of a child] to the police, and quite a number of abusers have been apprehended in the past and prosecuted, or jailed for their heinous crimes.”* **Interview with CSO 13**

Not only did the participants support the reporting of cases, but they also consistently followed up on the cases, as shared by one participant below:

*“There was a certain girl who had problems; she was a victim of gender-based violence, and we managed to handle the issue by reporting to the police station. We took part in the whole process, starting with the chief [referring to the administrative head of a location] until she had her rights protected.”* **Interview with CSO 2**

Linked to the reporting and referrals was the provision of services, which two participants spoke about. One interviewee mentioned that their response to GBV cases included psychosocial support and legal advice to survivors, as demonstrated in the quote below:

*“We also have paralegals and pro bono lawyers, and we pick up cases of gender-based violence. So, our psychosocial counsellor will be able to, at the first point of service delivery, pick up the*

*issue and get to understand and walk the journey with the young girl. But then through that, we also must engage the parents of the young girl.” Interview with CSO 5*

Gender based violence is a structural problem entrenched in patriarchal systems, economic reliance and the commodification of girls’ bodies. However, it emerged that programme interventions driven by the study participants were fully focused on addressing individual girls as victims failing to address underlying causes of girls’ susceptibility to early marriage and sexual violence (Keith et al. 2023). These individualised interventions are donor friendly with short term results failing to deliver the fundamental thesis of reproductive justice that focuses on dismantling power structures and structural blockers that impede bodily autonomy and agency.

The research participants did not restrict their involvement to reactive interventions but also regarded preventive interventions as important. In that regard, the participants collaborated with various stakeholders to create awareness on GBV, including educating girls, boys, and the community about the services available as shared below:

*“We are also doing sensitisation with women in partnership with an organisation called ‘Centre for Solidarity Justice’, so we train, and we do advocacy around issues on gender-based violence.”*

***Interview with CSO 4***

*“We create awareness, and we let the girls know that here is where we talk about issues to do with gender-based violence. We create awareness for the girls, and our CBO works with both genders, the girls and the boys.” Interview with CSO 1*

Even though most study participants engaged in awareness creation, feminist scholars continue to critique the use of behaviour change approaches in development programming contending that the approaches shift structural gaps to individuals (Rose 1999). Furthermore, studies have demonstrated that development initiatives that focus on awareness creation hardly achieve their intended objectives (Nyoni et al. 2023). A reproductive justice lens would interrogate power relations, and drivers on inequality, from the study it was clear that the CSOs targeted community members in general. This showcased a structural gap around in-depth male engagement, yet studies have shown that GBV programmes that adopt gender transformative approaches yield greater results compared to those that are victim centred (Park et al. 2022; Perez-Martinez et al. 2023).

From the interviewees, it was clear that legislation and policies were critical to GBV prevention and response, hence a focus on policy advocacy. Specifically, two participants stated that they lobbied for budgetary allocations towards the creation of rescue centres and the implementation of laws to combat GBV, as demonstrated below:

*“During the time that we were trying to advocate to at least have a rescue centre for GBV survivors, we did not have the policy on protection against gender-based violence. We had to first advocate for that policy to be established.”* **Interview with CSO**

**1**

The findings above demonstrate that CSOs implement activities targeting individual girls in as far as access to justice was concerned as well as pursuing political and legislative changes. A reproductive justice paradigm around SRH seeks to strengthen political commitment from all stakeholders as an enabler of sustainable SRH outcomes (Daigle & Spencer 2022). Political commitment is demonstrated through the allocation of financial resources towards implementing laws and policies related to curbing GBV; an action that was widely evident in this

study. Chapter Two expounded on the architecture of health governance in Kenya and its influence on health financing, including SRH services. CSOs thus focus on advocating for budgetary allocations for rescue centres and the push for legislation to combat GBV, at the county level, was aligned with the ideas of reproductive justice theory. Meanwhile, the CSOs would consistently need to navigate the invited participation tension in governance processes where they amplify their voices but not necessarily disrupting power imbalances that exacerbate GBV in the County (Cornwall & Coelho 2007). A reproductive justice lens portends that advocacy moves from invited to created spaces, where women, girls and communities actively demand for, and influence change.

This study found that partnerships were a critical ingredient in GBV programming. Many participants reported that they worked in collaboration with stakeholders in the county to create awareness on GBV as demonstrated below:

*“We have been working very closely with children’s welfare departments, the judiciary, the police, and the paralegals, just to escalate and ensure justice is done on issues of GBV among our young women.” Interview with CSO 13*

Partnerships is a popular catchphrase in development programming since the 1980s mostly promoted by donors with the aim of deconstructing hierarchy in the aid architecture. Critics note that partnerships was a neoliberal ideology focusing on achieving efficiency in development investments by transferring responsibilities to local people and less focus on equity (Hatery & Malhotra 1997). Therefore, findings in this study demonstrated how, through partnerships and collaborations, GBV issues are technocratized, in that investments in essential services like rescue centres must follow a technical policy process. In addition, through partnerships, results can be quantified based on the donors’ interests and guideline, with limited effort around dismantling patriarchal structures and norms that perpetuate GBV.

The study found that the CSOs and partners adopted a securitised approach to GBV programming, where activities are implemented from a protection paradigm, heavily focusing on reporting and follow ups, with minimal focus on justice elements. As a result, their interventions treated adolescent girls as passive victims and not active agents per a reproductive justice lens (Pupavac 2001; Grugel & Piper 2007; Wangamati 2020).

This subtheme indicates that CSOs made contributions to GBV prevention and response through reporting and referrals, community sensitisation and policy advocacy. However, these interventions are relevant as temporal measures but unprogressively from a reproductive justice standpoint as they fail to address deep seated structural barriers such as patriarchy.

#### **4.4.4 Community outreach and advocacy**

Access to SRH information is critical for the enjoyment of the right to health (Durojaye 2019). Adolescents access SRH information from formal and informal platforms, including digital platforms, school curricula, peers and family members (Njagi 2023; Wangamati 2020). This study found that community outreach was a substantial mechanism for ASRH programming at the community level for information sharing, as articulated below.

*“We focus not only on doing in-reach and outreach in schools and at local health care facilities with our youth advocates, but also in collaboration with the member organisations that we are partnering with.” Interview with CSO 6*

The deployment of community outreaches presupposes that lack of SRH information is the greatest impediment to adolescent girls’ sexual reproductive health rights. African feminists contend that the continuous focus on individual behaviour in global health interventions in Africa overshadows structural causes

of adolescent reproductive vulnerability (Ampofo et al. 2022). Similarly, Mama (2007; 2011; 2020) notes that African CSOs working on gender and health issues are epistemically circumscribed to Northern feminist frameworks that underscore individualised rights and result based behaviour change, while excluding culturally specific and historically situated dimensions of African women's reproductive lives.

The *Kenya National Adolescent Sexual Reproductive Health Policy* (2015) underscores the necessity of partnerships with stakeholders in the advancement of SRH rights at all levels. The implementation of this objective was observed in this study as the participants conducted outreaches in collaboration with the local government administration and national-level CSOs. One participant shared the following comment:

*“Sometimes you can get that there is a certain CBO in Bondo that wants to support an outreach in Bondo Sub - County Hospital or in any facility. Then we can come in as an organisation to support.”* **Interview with CSO 2**

In speaking about collaborative efforts around community outreach, the participants explained that they collaborated with other CSOs to implement donor-funded projects. A participant shared how that worked in practice:

*“For the community outreach, we rely on strategic partners like the Siaya Muungano Network and TiCAH Kenya, as well as Mildmay. So those are some of our short-term partners that we work with closely to implement community outreach.”* **Interview with CSO 5**

From this study, it is evident that community outreaches as a programmatic strategy and broader ASRH policies are beholden to donor driven lingua and logics such as partnership with government for legitimacy. Based on Wolch's

(1990) notion of the shadow state, the study participants functioned less as independent agents of social change and more as substitutes of service vacuums left by an under-resourced county health system. Consequently, they normalise rather than challenge the state's abdication of its duty to provide adolescent SRH information and services. Similarly, the implementation of community outreaches as part of donor projects highlights the danger in projectisation of adolescent SRH. Chapter 2 problematised the CSOs operating models and their impact on their social justice mission. Dependency on donor funding, short funding timelines and donor interests usurp CSOs advocacy mandate as they are co-opted into service delivery and rigid invited spaces that depoliticise their push for adolescent girls' SRH.

The research questions elicited participants' perceptions of the usefulness of community outreach as an SRH programming technique; they argued that it was successful because it resulted in an increase in the number of women and girls accessing SRH services at the facility level. An example of an outreach success, is recounted by this participant:

*“We were supporting the outreaches for different dispensaries and health centres in Bondo, so the right holders came in and accessed the long-term services. Last month we had an outreach in Kapingo, Bondo. We had three outreach sessions and really reached many women who are under-represented, they accessed services such as cervical cancer screening, counselling and they were given contraceptives. About 900 women came in those three days . We see that as a success story.”* **Interview with CSO 2**

From a reproductive justice lens, the community outreaches covered the right not to have a child by emphasizing on contraception and less of the right to have a child and the right to have a child in safe environments. This reflects on the donor preferences on fertility control and reproduction as preferred by international SRH

donors. Moreover, reproductive justice focuses on movement building where women and girls collectively hold duty bearers accountable as opposed to them being fronted as passive, waiting for services and information (Ross 2020).

Additionally, the study participants conflated short term outcomes with transformative SRH outcomes by highlighting their success in numbers. This approach that is resonant with results-based management highly promoted by donors, failing to acknowledge the complexity of SRH more so the structural barriers that cannot be quantified.

Intersectionality is at the centre of reproductive justice theory, where adolescents' full enjoyment of SRH rights interplays with different factors, such as poor service provision (Ninsiima et al. 2020). This was evidenced through a participant's account of how they used community outreach to promote public engagements on public financing. This is in stark contrast to other organisations that tended to use community outreach mainly for the dissemination of SRH information. A participant shared that:

*“What we do is basically a voluntary outreach where we discuss public issues and bring in other areas of concern within the community. Then we voice these concerns with the duty bearers, and it is always needed because this youth parliament is composed of mentors and volunteers from various organisations within this region.”* **Interview with CSO 3**

This section illuminated the role of community outreach in providing information related to SRH to adolescent girls and communities at large although the outreaches were individualised, reproducing northern epistemologies. That is, using a standard community outreach approach to transfer information on SRH and assuming that, that would influence access to SRH services. Based on the CSOs accounts, sexual and reproductive health issues intertwined with local governance issues, challenging the singular perspective of individual choices

made by adolescents over their health (Potvin 2019). The intersection between SRH and governance issues such as the allocation of budgets for health services is discussed in the next section.

#### **4.5 MOVING FROM INVITED TO CREATED SPACES: CSO POLICY ADVOCACY**

This section discusses the theme of policy advocacy which emerged as a core programme intervention during the interviews. This finding concurs with the work of Cooper (2018), who contends that advocacy is a major function of civil society organisations in driving social change. Fundamentally, the participants narrated that their advocacy focused on agitating for the implementation of SRH policies and allocation of budgets towards implementation of adolescent sexual reproductive health policies and programmes. This sub-theme covered influencing policy implementation via stakeholder collaboration, advocacy for the rights of the marginalised and accountability via research and a watchdog role.

Regarding advocacy geared towards implementation of SRH policies, CSOs deployed different tactics to influence policymakers and legislators to achieve positive outcomes. The strategies included building allyship with relevant local and global stakeholders in government and civil society organisations. This tactic resonates with Nordback (2020), who found that multi-stakeholder dialogue was vital in influencing policy changes in the context of sexual and reproductive health rights. The quotations below demonstrate participants' experiences:

*“Our advocacy work is centred around the different allies that we are working with...at the SRH level, we focus on issues around policy. When you look at the policy angle, a lot of it comes from the executive. So, we are very intentional in working with the other government allies within these spaces, be it at the Sub - County or county level.” Interview with CSO 8*

*We engage in advocacy efforts to at least try and influence policy makers to implement and strengthen issues of sexual and reproductive health rights. And we work with a couple of partners both locally and internationally to amplify voices and to advocate for change within our local communities.”* **Interview with CSO 13**

Civil society organisations play a critical role in policy advocacy, especially in promoting an enabling environment that challenges and tackles systemic oppression of marginalised groups, within the reproductive health ecosystem (Hyatt et al. 2022). The review of literature in Chapter Two pointed out progress on sexual and reproductive health rights, since the ICPD in 1994, although specific elements remained contentious, especially the SRH rights of sexual minorities (Brown et al. 2019). In the same regard, only two study participants advocated for the SRH rights of sexual minorities and persons with disabilities, as demonstrated below:

*“We also try to ensure that SRH services are inclusive and accessible to all, including even the LGBTQIA+ or the sexual minorities and persons with disabilities. As a result, we collaborate with advocacy groups that represent marginalised communities to try and address their specific SRH needs.”*

**Interview with CSO 4**

As highlighted in Chapter Two, SRH programming is contentious due to religious and cultural perspectives, and engagements with sexual minorities are more complex, as shared by one participant below:

*“... I do tell the people that I am fighting for the sexual and reproductive health rights of LGBTQIA+. I am not promoting homosexuality, or anything like that. People who identify with another gender or with a different sexual preference are normal human beings...we are all the same... The Constitution states*

*that everyone has sexual and reproductive health rights.”*

***Interview with CSO 8***

The first quotation above shows the engagement about sexual minorities as including LGBTQIA+ people, as well as people living with disabilities, the second quotation clearly reveals stigmatisation in this regard. The fact that only two of the participating organisations mentioned this and the way that the discussions framed the normative concerns about what ‘normal’ sexuality means, is an indication that the current ASRH programming was insufficiently inclusive. This fell below the standard set by Article 43 (1) (a) of the Kenyan Constitution, which affirms that everyone has a right to the best health possible, including reproductive health care and Section 6 of the Health Act (2017), which states that every person has the right to reproductive health care (Government of Kenya 2017).

From an African feminist perspective, marginalisation of LGBTQIA+ moves beyond a service delivery gap, as it illuminates the remnants of colonial legacy, often channelled through religion (Tamale 2011). Even though, Oyewumi (1997) contends that traditional African society was not strictly organised along gender lines, this finding affirms that the *Luo* culture is organised along the male and female binary based on sex at birth. Moreover, the CSO workers desire to delink themselves from promoting homosexuality and quote the constitution at the same time exhibits the tensions that CSO workers must navigate.

Whilst there has been progress on SRH-related issues, since the ICPD in 1994, persons living with disabilities have been significantly left behind for many reasons, including negative attitudes towards them in general and specifically health service providers’ attitudes (Shakespeare et al. 2019). Other studies confirm that less attention has been given to the reproductive liberties of persons living with disabilities, and they are excluded from shaping health policies, systems and programmes (Kleintjes et al. 2020; Knight 2017). This finding affirms that sexual and reproductive health intersects with other forms of oppression,

including marginalisation and exclusion of sexual minorities who indiscriminately face a disproportionate burden of poor sexual and reproductive health (McLeod et al. 2024).

The study participants indicated that part of their advocacy was focused on driving accountability and demanding services from the county government. The objective of their advocacy efforts was to ensure that women and girls were fully enjoying the right to health as articulated in the Constitution of Kenya and other SRH-related policies and legislations discussed in Chapter Two. At the same time, reproductive justice theory analyses the influence of policies and distribution of resources across all groups of women and takes cognisance of the impact of inequality on women's health (Morison 2021). Conversely, the participants' mandate around advocacy was geared towards ensuring that resources were invested in SRH, as elaborated below:

*“We are an advocacy organisation, so we focus more on creating demand, which we do through sensitisation and information sharing with the public. But then apart from that, we are also engaging with the duty bearers just to make sure they have the capacity and structures to meet the demand that has been created. We do it through budget accountability forums and participating in budget-making processes to lobby for adequate resources on adolescent health.”* **Interview with CSO 13**

The quotation above demonstrates how CSOs interventions work along neoliberal and social justice continuums, specifically, they deliver individualised interventions through sensitisation and information sharing. After which, they fill up governance vacuums by building capacity of government and then move towards advocacy. Whilst these interventions are critical and relevant to the Siaya County context, studies have shown that CSOs move away from their core mandate when they fall into mission creep (Wolch 1990; Hearn & Lavers 2022).

The study revealed that budget advocacy was deployed as a strategy, focusing on influencing the government's practices around resource allocation and expenditure for sexual and reproductive health interventions. Budget advocacy is a form of participatory budgeting where individuals and organised groups inform how public finances are allocated and managed (Meléndez 2021). The participants noted that they presented memoranda to the county government and conducted research to produce tangible evidence. From the vantage point of reproductive justice, budget advocacy together with youth and communities is important for movement building and solidarity (Ross 2020). One participant shared how they engaged in budget advocacy:

*“We are very intentional in terms of the budget advocacy that it is not led by our organisation but instead led by youth advocates and institutions... basically working in the areas where we are implementing our projects for community ownership, and scalability beyond what the organisations’ resources.”* **Interview with CSO 2**

*“We also do budget advocacy, where we do memoranda that we hand over to officials within the county; however, we cannot reach the national level.”* **Interview with CSO 3**

The participants indicated that research was a critical tool used by civil society organisations in their watchdog role, and they indicated that they invested in evidence generation and used the findings to lobby for budgetary adjustments at the county level. This finding supports other studies which found that CSOs are a link between the populace and policy decision-makers through their advocacy work (Espinosa & Rangel 2022; Smith et al. 2017). The study participants deployed their watchdog role in various ways, including strengthening states' capacity to deliver on their mandate, agitating for policy reforms, and generating evidence (Maslen 2023).

From a reproductive justice lens, advocacy is about movement building, solidarity and collective voices by those impacted by SRH inequalities (Ross 2020). The study participants account of the budget advocacy process referenced what they did as institutions, and less of how they brought the adolescent girls' together with them in the advocacy process. At the same time, elements of technocratization emerged in their advocacy process more so the need for research, data and evidence around SRH gaps to legitimise their advocacy claims. This affirms Ahinkorah et al. (2021) who observed that global SRH programmes are heavily infiltrated by neoliberal logics and most social justice oriented CSOs coexist, manage or get usurped in it.

A recurring theme in the research participants' interviews about their advocacy work was a push for more family planning commodities at facility levels, specifically contraceptives. Participants indicated that one challenge facing adolescent girls in their programming areas was the unavailability of family planning commodities, including contraceptives and HIV testing kits. The first quote below describes the challenge of commodity stockouts, referring to a scenario when a vital medical supply, such as a prescription drug or equipment, is entirely out of stock. This means that patients are unable to obtain that item at that time, which may impact the quality of their care and treatment (Atiga et al. 2023).

*“There are those commodities which are beyond our control such as the HIV testing kits. It is the responsibility of a specific organisation [referring to the Kenya Medical Supplies Agency KEMSA] within Siaya County to provide them within the facilities.”*

***Interview with CSO 5***

To address the issue of stockouts, especially for contraceptives, CSOs deployed their watchdog role by generating evidence through research and holding relevant government departments accountable for delivery, as shared below:

*“One of the research engagements that we did a couple of months ago was the development of an FP tracker in terms of commodity access in healthcare facilities, and we were able to do this in one of the facilities in Alego.... that is Kapiyo. And what emerged during that action was an understanding of how frequently these commodities were accessed. There were issues around stockouts.” Interview with CSO 8*

This subtheme uncovers a recurring focus on supply chains in SRH programming adopted by CSOs and government a reflection of international donors’ priorities. The study participants showcased how donor architecture preferred output driven reproductive health programming, a concept that Merry (2006) termed as vernacularisation referring to a situation where donors translate global SRH norms into actionable interventions. This finding resonates with literature reviewed in Chapter Two where major donors shaped family planning discourse under neoliberal logics (Bhatia 2020; Wilson 2018).

Mangwana et al. (2023) demonstrated in Chapter Two that among the technical capacities required of a civil society organisation with advocacy mandates was research and budget advocacy, skills that some study participants exemplified. To situate advocacy and adolescent sexual and reproductive health within the county development and governance agenda, the participants framed high rates of unplanned adolescent pregnancies as a socioeconomic development issue. In their view, it was a convenient entry point for engagements with the county government. One participant indicated:

*“Our first strategy was to present issues around adolescent pregnancy as a development issue. For example, if you have one adolescent who is pregnant, what is the cost implication to the county? And then the other thing is, if you have young people on contraceptives, what is the added value? For example, at the*

*national level, for every shilling you spend on contraceptives, you are likely to save four shillings.” Interview with CSO 9*

The quote above brings to the fore the exploitation of adolescent pregnancy for the leverage of budget allocation by presenting it as a major cause of poor levels of development, instead of addressing the structural causes. Participants used this as a tactic to secure a place on the national agenda for SRH conversations and for investments in their budgets by the government. This finding correlates with Oranje (2013), who proffers that SRH in the context of human rights remains contested, beset by a lack of political will to support a rights-based SRH agenda. By framing adolescent pregnancy as a cause of poor development, governments that are duty bearers, might be better persuaded to engage with and act on SRH-related matters. Theobald et al. (2005) suggest that in many African countries, bureaucrats present gender issues using technical, risk-based narratives, whereas civil society deploys narratives about equity and rights.

The downside of the securitisation of adolescent pregnancy in facilitating budget advocacy was the exacerbation of risk-based perspectives on adolescent pregnancy (Feltham-King 2015). Coupled with this is the government's dogmatic and severe approach to managing adolescent pregnancies, which is translated into formulation of policies and controlling SRH services and information required (Du Plessis & Macleod 2023). The literature reviewed in Chapter Two identified barriers to reproductive justice; these are further unpacked in Section 4.4 elaborating policy implications of the securitisation of adolescent pregnancy to include gagging rules for SRH information, a preference for abstinence-only sex education, and gatekeeping of SRH services with increased requirements for adult consent – all of which disempower adolescent girls.

The study participants noted that family planning conversations were framed from an economic development perspective, furthering the neoliberal connotations of individual access and treatment of women and girls as a market site where private sector players have an opportunity to expand ‘women’s options’ (Bhatia et al.

2024; Howerton 2021). Literature reviewed in Chapter Two indicated that the adoption of language such as ‘family planning commodities’ is reflective of the framings adopted by institutions like BMGF, who fund family planning programmes, but who have been found to have commercial interests for doing so (Nandagiri 2021; Wilson 2018).

The foregoing paragraphs have clearly articulated the tensions between sexual and reproductive health rights, from a public health and economic perspective versus a justice-based perspective. A reproductive justice lens deliberately identifies how power plays out and how power threatens inclusion and pushes marginalised populations, such as women and girls, further into the periphery. Overall, whilst engagement with government was critical, civil society organisations had to work out a balance between promoting a justice agenda and adjusting to governments’ preferred ways of working.

From the interviews, it emerged that civil society organisations provided alternative approaches to budgeting to the government, a role that is envisaged of civil society organisations under a rights-based approach to development (Rask et al. 2023). It is envisaged that CSOs under their watchdog functionality provide technical assistance to the government by ensuring that the plight of the marginalised is recognised (Maslen 2023). The quotations below outline two participants’ experiences:

*“Then there is the aspect of working with the policymakers around domestic financing, and that’s looking at the budgetary processes by doing analysis, providing a critique, looking at how that has been done and then a follow-up on the status.”*

**Interview with CSO 9**

*“Together we can formulate an action plan that can create a win-win situation for all of us. Even though, at the end, the result would not be documented as a win by a single organisation only.”*

*Instead, a good result is the outcome of the actions being owned by both the right holders and the duty bearers in that county.”*

***Interview with CSO 8***

The researcher noted that civil society organisations deployed tactical strategies to influence government from the insider vantage point, as most of them were part of different government-instituted technical working groups. Others provided technical support to government-led processes by draughting key policy frameworks. The quotes below demonstrate how the participants applied themselves at the technical working groups:

*“We are part of the county’s technical working groups... specifically for Sexual and Reproductive Health, and most of the time we reach out to partners and other entities that are implementing projects in the same area of work.... Those are the partners that we interact more with and give our feedback on what happens in Ugenya Sub - County. We have different partners doing different SRH services in different sub-counties. So, when we meet and raise these challenges, the reproductive health coordinator at the county level is able to push it at the county assembly level or further.”* ***Interview with CSO 6***

*“We are the technical leaders for the county in terms of the development of their family planning cost-implementation plan as well as their adolescent and youth, SRHR and HIV frameworks... and so, these were well completed. This now provides a bit of a framework on how different partners can be able to align with the county priorities.”* ***Interview with CSO 9***

The quotes above demonstrate that part of policy advocacy was influencing relevant partners, especially government, through the provision of technical assistance which opened spaces for dialogue and consultation. This partnership

between civil society and government was envisioned under the *Kenya National Adolescent Sexual and Reproductive Health Policy* (2015). From a reproductive justice viewpoint, access to SRH is governed by several interconnected factors, and the availability of policies and legislation is critical because they unlock funds and legitimise CSO and community claims for specific rights. By CSOs influencing policymaking, they move from individualised choices to macro issues such as public financing that influence sustainable health outcomes for adolescent girls (Oraro-Lawrence & Wyss 2020).

Even though technical working groups were highlighted as strategic spaces to lobby and influence policymaking on adolescent sexual and reproductive health issues, some participants indicated that there were downsides to these engagements. Specifically, it was noted that ultimate decision-making was at the behest of government and that the short-term nature of SRH projects challenged the sustainability of processes altogether. On the matter related to decision-making by government, a participant had this to say:

*“There is a technical working group for SRH and for gender-based violence. So, these Technical Working Groups are integrated together with the County Health and Sub - County Health Management Teams. Through these groups we can make proposals on what we think can work and how best those issues can be addressed within the County and Sub - County . Ours is to air out the issues that we feel are affecting service delivery to them, and then, you know, now it’s at their level. We can just do follow-up; there is not much we can do; it is just follow-up and waiting on the feedback from their end.”* **Interview with CSO 4**

The quotation shows that consultation with CSOs can become empty check-box activities that may not result in larger justice-based changes. Technical working groups are an example of invited spaces that governments use to incorporate public engagement in decision-making processes (Visser et al. 2021). The

findings above relate to decision-making which aligns with the conclusions reached by Ntwana & Naidoo (2024), who argue that the relevance of invited spaces can be limited because decision-making is controlled by political representatives who serve their own interests. Critics have also cautioned against the neo liberalisation of civil society organisations, as evidenced in Chapter Two, where it was found that women's rights issues were technocratized and professionalised by incorporating CSOs in government-instituted structures, like technical working groups (Chakraborty 2021; Gutheil & Koch 2023).

Participants in the study also noted that the irregular participation in technical working groups, which resulted from CSOs' incapacity to engage outside of designated financing cycles, was a challenge. As a result, activities were, therefore not definitively concluded, and a new agenda would be established based on the financial availability and the new CSOs' agenda as elaborated below:

*“At times we have a team of maybe five organisations in that technical working group. And that organisation is supposed to be implementing... maybe for a period of two or three years. When they exit, they exit in a way that the Technical Working Group is not even aware. At times, they are branded as briefcase organisations. They just implement what they came to implement and just exit when their time comes. Or maybe you find that, for example, our organisation wants to support an SRH policy. In that case, we will support those meetings and follow up, and in case the policy has not been adopted by the time the project ends, then that policy ends at that point. Nobody will follow up. And then we'll have a new Technical Working Group, including other new members who will also have different interests that they would like to be following within the county.”* **Interview with CSO 5**

Studies have found that sustainability of CSO interventions continues to be a challenge worldwide, and short-term funding cycles have been proven to impede transformational programming and impact since CSOs focus on delivering short-term results (Bosibori 2021; Gul & Morande 2023). Moreover, NGOisation of projects depicts a structural feature of project based CSO advocacy where activities such as budget advocacy, submission of memoranda and hosting of technical working group are quantifiable and can be easily reported back to donors (Lang 2022).

The researcher enquired about the participants' perceived notions on the effectiveness of their advocacy work, and it was reported that over time, they had influenced the government's allocation of financial resources for the benefit of adolescents and young people in Siaya. The excerpt below refers to this:

*“The county was allocating... I think a sum of three million yearly on setting up a youth wellness centre or a youth-friendly centre. So, this money was not being utilised; it was just disappearing into thin air. We advocated until the County was forced to collaborate with a partner and now there is a functional youth-friendly centre in Siaya... it's one of a kind... and it's situated in Bondo Sub - County .” Interview with CSO 13*

This study acknowledges and recognises the value that CSOs advocacy activities deliver for instance, financing of the youth friendly centre in Bondo, however, it can be argued that budget analysis, engagement in technical working groups and submission of budget memoranda are unequivocally northern development processes. The same opinion is held by African feminists like Arhin-Sam & Obeng-Odoom (2022) who assert that African gender and health CSOs reproduce colonial epistemological hierarchies by failing to generate knowledge from their areas of programming on what reproductive autonomy and justice would mean in those contexts. Similarly, the participants did not

demonstrate how they deployed indigenous *Luo* knowledge systems on governance and accountability.

The role of CSOs in policy advocacy is in line with a reproductive justice agenda where systemic issues that hinder access to SRH rights are analysed and addressed. The interviews revealed that the CSOs advocated for financing, accountable spending, and increased provision of contraceptives, as well as providing technical guidance on how to plan for these provisions. Reproductive justice elevates personal SRH needs to the political agenda, and by CSOs tackling systemic issues such as financing, they were bringing to the fore the plight of adolescent girls.

#### **4.6 DECONSTRUCTING BARRIERS TO ADOLESCENT GIRLS' REPRODUCTIVE JUSTICE**

Earlier chapters indicated that comprehensive access to sexual and reproductive health continues to be evasive in most parts of the world and especially in Kenya. One of the key objectives for this study was to assess the internal and external factors that influence ASRH programme interventions by CSOs in Siaya County. This broader objective was assessed from a reproductive justice perspective which challenged individuality and hegemonic femininity, expanding perspectives to include power relations as well as social and political factors that intersect to deny adolescent girls their SRH rights. This theme clustered around pre- and post-pregnancy factors that blocked adolescent girls' reproductive justice. This theme had four sub-themes, namely, sociocultural perspectives on adolescent sexual and reproductive health, the politics of comprehensive sexuality education, gender dynamics and power relations, and limited access to SRH commodities and services.

#### **4.6.1 Sociocultural perspectives on adolescent sexual and reproductive health**

The participants identified sociocultural perspectives as a factor impeding adolescent girls' full enjoyment of sexual and reproductive health rights. To begin with, Siaya County being a rural area, with people predominantly from the *Luo* ethnicity, culture played a role in terms of what was perceived as socially appropriate. The interviews revealed that andropatriarchal norms in the area made men the main referent subjects whose sexual and reproductive health must be protected, abandoning adolescent girls' need for body autonomy. For example, one participant shared the following:

*“Culture is the biggest barrier in terms of reproductive justice.... more so because Siaya is a purely rural county. Traditional cultural ideas stop women from claiming their full body autonomy. For example, when you're speaking of contraception, you will soon get the impression that men are the only people entitled to receive male condoms. But what about female condoms or IUDs?” Interview with CSO 8*

Another response that referenced taken-for-granted normative beliefs, related to *Luo* culture, was a normalising of sexual violence and accepting of the early initiation of sexual intercourse. In fact, incidents of sexual violence were seen as normal, personal matters that should not be interfered with by the authorities. These practices consequently presented a barrier to women's access to justice in the case of gender-based violence.

*“There is a belief that a girl child that starts getting periods is ready for sex. There are sayings that if you have sex with a small girl, then your HIV gets cured.” Interview with CSO 12*

Another participant added:

*“Sometimes when rights are violated, then culture is invoked as the excuse. And that limits access to justice. For example, when there’s an incident on defilement or something, then people tend to collude with one another, and then justice is just denied, just like that. So, no redress.” Interview with CSO 7*

The foregoing paragraphs align with Otieno (2023), who posited that the women in the *Luo* community are perceived as inferior, and this always paves the way for misappropriation of their bodies. These perspectives explain why access to SRH services such as women’s contraception is shunned, and preference is given to the sexual health and rights of men. Equally, sexual violence is condoned based on culturally accepted sexual objectification and control of women and their bodies in a patrilineal society (Philip et al. 2015).

Another aspect where sociocultural beliefs were narrated as a barrier relates to how andropatriarchy excluded women from productive activities like farming and education, which in turn hindered their ability to build socio-economic assets and to establish a basis for autonomous decision-making. For example:

*“There is this thing where women are told that when they are menstruating, they must not even go to the farm to harvest vegetables, because that would make the crops and yields dry up. Interview with CSO 12*

*You know some communities really don’t push for girls’ education. If you have a girl....a boy will be given priority to go to school, and if a girl doesn’t complete or transit to the next level of education, it’s just not an issue.” Interview with CSO 7*

The observations above are congruent with those of Otieno (2023) and Philip et al. (2015) that the Luo culture emphasises women's dependency on and subordination to men. The study further found that those sociocultural beliefs around sexuality influenced adolescent girls' access to SRH services.

The findings under this subtheme demonstrate that culture counteracts reproductive justice's tripartite rights. On the right to have children, adolescent girls are highly likely to have unplanned pregnancy given the normalisation of sexual violence. With regards to the right not to have children, adolescent girls in Siaya County lack the autonomy to access contraception as this is curtailed by male domination of their bodily autonomy. Altogether, a cultural environment that discourages an adolescent girls' education and socio-economic empowerment erode their right to parent in safe environments.

To address the socio-cultural norms around sexual violence, exclusion of women from socio-economic opportunities and male dominance, CSOs are required to implement more transformative interventions beyond awareness creation. Mama (2020) alludes that African women's oppression is reproduced through systems of knowledge production that render the said social norms invisible. For instance, while cultural norms are a barrier to reproductive justice, it must also be seen as a variable reproduced within health systems, legislation and CSO programming approaches. A reproductive justice lens uncovers the tension between CSO's individualised responses to cultural barriers and the transference of the burden of navigating dysfunctional systems to individuals. Morison (2021) maintains that SRH must be re-politicised as it is not a technical problem with clear cut logical solutions that could be solved through information sharing.

Even though this study was focused on adolescent pregnancy as an adolescent SRH issue, it emerged that the rights of sexual minorities were eminent. From the participant interviews, it was clear that homosexuality was frowned upon, leading to discrimination against sexual minorities, especially those seeking

sexual and reproductive health services. The first quotation below speaks of the interviewees' reluctance to breach the topic of LGBTQIA+ for fear of a backlash. The second quote illustrates the interviewee's struggles to be accepted for same-sex relationship.

*“There are a lot of myths, beliefs and misconceptions when it comes to culture that at times seem to be so impenetrable. Because this is something that has been engraved in people since their childhood. For instance, if you want to talk about the current issues of LGBTQIA+ there are high chances that stones thrown at you even before you complete your statement”.*

**Interview with CSO 4**

*“When I walk into a facility with my sexual partner, people or the service provider are there like, why are you coming, you know, two people of the same sex? And at that time, we want a crucial service like an HIV-testing. But now we cannot get those services because of discrimination. From the research I have read, I know that HIV prevalence is high in Siaya County and within sexual minorities. This is because they cannot get proper health care services.”* **Interview with CSO 16**

The quotes above are consistent with other studies that have shown that LGBTQIA+ persons continue to face discrimination and exclusion across different spheres of life, and this impacts their sexual reproductive health and rights (McLeod et al. 2024; Pincock 2021; Izugbara et al. 2020). African feminists thought maintains that discrimination of LGBTQIA+ persons and the criminalisation of same sex relationships is rooted in colonial governance and interpreted concomitantly with religion (Ekine & Abbas 2013; Tamale 2011). Collectively, discrimination of LGBTQIA+ must be viewed, not only as a service delivery gap but rather a structural and postcolonial challenge.

The discussions on norms and values were not only based on resistant sociocultural and gender norms but also extended to the role played by religion. In this regard, the study participants unanimously concurred that religious views influenced communities' perceptions and life choices around sexual and reproductive health issues, as illustrated by the first quote below.

*“There was a time that we were doing facilitation in the community, and we were sharing information and wanted to get their views on issues around family planning. One of the male participants stood up and said, why should we embrace family planning, when God himself told us that we should give birth and multiply the earth”* **Interview with CSO 7**

To further expose the role of religion in influencing individual and collective perspectives on sexual and reproductive health, a participant alluded to Catholicism being prevalent in their regions of operation and that adherents were influenced by these ideas. Participants told the researcher of their fears that religious beliefs pathologised the use of family planning and stigmatised young girls who sought access to contraceptives, as expressed below:

*“Currently we experience a lot of religious barriers, like certain religions do not accept issuing of certain contraceptive commodities to their congregants.”* **Interview with CSO 17**

*“I am a Catholic, and our bishops don't promote the use of contraception. If you go to communities that have got Catholic churches, you cannot really talk about, for example, a condom, and you realise that in the region where we work, the Catholic Church is quite dominant. When you use contraception; you are branded as immoral. When issues of immorality come in, then you're not a good girl. That already profiles people, and it creates an environment of stigmatisation ....”* **Interview with CSO 7**

The Catholic church has a stronghold on its adherents given their role in providing education and healthcare services in pre- and post-colonial Kenya (Omunyin 2026). Taken together, they leverage their moral legitimacy to influence their congregants SRH ideologies which are taken as a core element of their spiritual and daily lives (Nduku & Wafula 2023).

Another participant indicated that religious beliefs hindered adolescent girls from accessing information, which impeded their understanding of the changes in their bodies. This interviewee related a recent experience of rituals related to girls' menses that render this normal part of human development as somehow abnormal.

*“There is a woman who is of the Legion of Mary religion who indicated to me that there are sacrifices that are done when a girl starts her period. She said that they need a chicken that hasn't started laying eggs, and a cow, and the child wears a head scarf because she has already started her period. Through this, there's something we are really fixing in the mind of this girl, so she will always see menstruation as something strange in her body.” Interview with CSO 12*

The participant narrations above agree with those of Alomair et al. (2020), who found that religion and culture influenced followers' education and life choices. On the contrary, other studies have found that religious leaders played a role in promoting ASRH, albeit from an abstinence perspective (Baturaine & Kizito 2021). From a reproductive justice lens, girls need to have the capacity to make decisions over their own bodies based on accurate information, however, the religious positions discussed above blocked their ability to act on the information they receive regarding SRH hence hindering their body autonomy. A post-colonial African feminist lens posits that religious conservatism in sub-Saharan Africa is not a precolonial acquisition but rather a colonial imposition where Christian missionaries deliberately merged religious and indigenous patriarchy to

produce a bolstered system of African women's bodily oppression (Tamale 2011).

Another issue that came to the fore in the narrations, as befitting the theme of norms and values, was how the community perceived the age of consent and adolescents. In this regard, a participant engaged in the provision of SRH services indicated that the community's attitudes about sexual and reproductive health influenced how they delivered services to adolescent girls.

*“Some of the community members will generally consider anyone, especially women, below 18 years as a child. So, we do not give them any service without their guardian's consent, especially family planning....” Interview with CSO 6*

The quotation above aligns with Kenya's *Reproductive Health Policy (2022-2032)*, which places responsibility for reproductive health interventions for children under the age of 18 years with parents, guardians and the government. The efforts of civil society organisations are restricted by policies and legal environments which also influence the communities' norms and perceptions of adolescent sexual and reproductive health. Chapter Two discussed the tensions between adolescent girls' agency and autonomy to make independent decisions against parental responsibility and state regulation when it comes to young people accessing SRH services, such as contraception and pregnancy termination (Moyo 2018). Article 5 and 14 (2) of the UNCRC envisages that children have evolving capacities, reaffirming that they are right holders with agency to exercise their rights as they mature at different levels (Varadan 2019). However, this study affirmed findings from Warioba (2018), who argued that the principle of evolving capacities is not applied in many African contexts when establishing thresholds for access to SRH services, such as access to contraception and pregnancy termination.

One participant indicated that culture, social norms and perspectives on sexual and reproductive health were found to be influenced by social media, hence, culture is not viewed as immutable. The participant attributed the shifts in culture to increased access to information via social media and peers as described below:

*“Culture is not much of a barrier because people are talking about these issues in social media; every now and then you hear people talking about them on the radio and all that”.* **Interview with CSO 4**

Another participant, however felt that social media and the influence of peers were detrimental to CSO’s causes and normalised adolescent pregnancy, making it appear fashionable:

*“Now the 21st-century problem again is girls seeing pregnancy as something fashionable. A lot of villages here are like that. So, you find even if you are having those programmes, some girls influence others by telling them that they are not going to finish Form Four without having a baby. So, they go seeking that pregnancy just for the sake of fashion because all her friends are pregnant. Which is a very big problem now. Though that is not in any way related to the traditions or culture. But then it is something that is really coming up so fast.”* **Interview with CSO 10**

This finding is important as it illuminated the dynamism of African culture, a move away from representing African culture as static and monolithic (Ampofo et al. 2022). An African feminist adaptation would capitalise on this dynamism and assess the structures that expose adolescent girls to cultural changes with the potential to increase their reproductive autonomy. Substantively, an African feminist lens would focus on assessing the structural conditions that would

prompt adolescent girls to seek social recognition to the extent of settling for counterproductive decisions such as having a child in the adolescent years. Al-Shdayfat et al. (2019) underscore the importance of digital platforms and social media in increasing adolescents' access to SRH information, especially, in contexts where parents, peers and institutions are not preferred sources of information. This study unearthed the influence of social media in adolescent girls' choices around their sexuality as well as catalysing social norms in a rural context.

#### **4.6.2 Politics of comprehensive sexuality education**

According to the research participants, limited access to comprehensive sexuality education (CSE) was a barrier to adolescent reproductive justice. Literature reviewed in Chapter Two affirmed the role of CSE in providing SRH information to adolescents worldwide and in Kenya (Guttmacher 2018; Republic of Kenya 2015; UNESCO 2021; UNESCO Institute of Statistics 2019). CSE is implemented in response to increased adolescent pregnancy and scarce SRH information among adolescents. It is, however, marred by ideological perspectives which slow down implementation of comprehensive sexual education with a focus on abstinence and life skills at the expense of issues related to contraception and abortion (Wangamati 2020). Likewise, topics such as contraception, sexual pleasure and sexual identity have been tagged as 'un-African' with the capacity to erode young people's morals, hence the pushback against CSE (Achen et al. 2023). As a result, adolescents are deprived of information that facilitates their decision-making around their sexual and reproductive health, as the quote below shows:

*“Comprehensive sexuality education is not allowed in our schools. Sometimes we find that we have laws at the national level, but then they are not applicable sometimes on the ground [referring to the county level]. When I am talking about accessing*

*the highest attainable standards of health, then that means that information is part of access to health.” Interview with CSO 10*

African feminists contend that the characterisation of CSE as un-African is not only a cultural dynamic, but a political act. To illustrate this, Shule (2018) proffers that using the term un-African was never intended to protect African culture rather, African governments used it as a tool post-independence to regulate sexuality.

At the same time, this study found that CSE was offered to in-school adolescents through life skills education, delivered by teachers who lacked the technical capacity and training to deliver the content as illustrated below:

*“You will find that a teacher who has totally nothing, no knowledge on reproductive health, maybe a teacher taking History as a subject, is teaching life skills.” Interview with CSO 13*

The finding above supports Ogolla & Ondia (2019), who stated that curricula offering CSE were found to be deficient since they were facilitated by generalist teachers with personal prejudices and ideas on sex and sexuality and without the technical ability and training on values clarification and unconscious bias, making the approach defeatist. Likewise, Helleve et al. (2009) seminal work on CSE postulated that the delivery of CSE through untrained teachers was inherently a structural disposition. They argued that teachers are gate keepers of school systems, institutional order and communal expectations, thereby trainings on CSE would be insufficient. Tamale (2020) extends this critique by noting that schools are like ‘factory machines’ for social rules designed to configure a docile, agreeable and asexual girl and the teachers’ role is to ensure that the girls are compliant.

The second finding around complexities with comprehensive sexuality education was the continuous struggle by CSOs to deliver age-appropriate SRH information. Age appropriateness is a principle outlined by UNESCO's guidance on the implementation of CSE and adopted in various Kenyan policies, including the *Education Sector Policy on HIV and AIDS*, the *School Health Policy* (2018), the *Return to School Policy* (1994) and the *Kenya National Adolescent Sexual and Reproductive Health Policy* (2015). The participants were aware that a lack of relevant knowledge restricted adolescents' decision-making about their bodies and sexual health, however, they admitted that they struggled to decide what age-appropriate sexuality education they should deliver to adolescents. They explained that this was primarily due to their personal awareness that adolescents are sexually active or introduced to sex at a young age, but that dealing with mixed-age groups remained difficult, as illustrated below.

*“Working with teenagers is the main challenge, having to conceal information or knowing the suitable level of information that I should go for with a particular person. There are those young people who, at Class Seven, are already exposed to sex. We share detailed information on gender-based violence, STIs, and HIV. And then there are other young people where you know you cannot get into too much detail. So, it is a broad range of information needs, but how deep you need to go with the SRH information for a particular level of young people remains a vague idea.”* **Interview with CSO 6**

Another participant added:

*“Since we meet different ages during our interactions, we package information depending on the audience that we are having. For example, if we are meeting kids in school, then we know that comprehensive sexuality education is not allowed in Kenya”.* **Interview with CSO 10**

Chandra-Mouli, Camacho and Michaud (2013) whose work influenced the design of the international CSE guidance highlight the inconsistency around the implementation of the guidance. They indicate that the standard on age appropriateness is consistently deployed to withhold information from sexually active adolescents navigating coercion or pregnancy. Equally, Nyanzi, Pool & Kinsman (2001) analysed body politics and education in Uganda, finding that adolescent girls are denied information that they need until adult institutions decide on the appropriate time to provide information regardless of circumstances. This study found that class seven girls were already sexually active, yet information shared was still unclear and chastity focused, denoting that this was less of a pedagogical gap but a political ineptitude.

The third complexity around CSE was government regulations and control through the Ministry of Education, which were said to constrain CSOs' access to schools and the type of information on comprehensive sexuality education delivered through schools. A participant shared the following:

*“The school would say that the Ministry of Education is not much into this (comprehensive sexuality education). Sometimes they feel like you want to expose these girls to a lot. You can't necessarily say that when you're going to schools and carrying condoms.... ; But within the community, that one can be done”.*

***Interview with CSO 11***

Another participant states:

*“I know, sometimes the Education Act has a bit of stringent measures in terms of the access to schools and how children can be interacted with in schools. The Ministry is very particular in terms of when we can meet these girls. We cannot meet them during school hours or during lesson hours. And sometimes*

*during games they have limited time to participate in these activities.” Interview with CSO 7*

The findings above correspond to a study conducted by the Centre for the Study of Adolescents, in Nairobi County, where CSOs pointed out that the government’s support towards CSE was declining and that there were conversations around omitting it from the revised Adolescent Sexual and Reproductive Health Policy. In addition, the Ministry of Education’s restrictions on CSOs conducting SRH activities with students were observed (Centre for the Study of Adolescence 2023). Observably, the MoE is an institutional gatekeeper to CSE, Ngugi wa Thiong’o (1986) and Kabira & Nzioki (1993) noted that the Kenyan education system sustained colonial systems that sought to keep learners obedient and pure by averting some types of information. Overall, MoE’s gatekeeping tendencies are designed to exercise institutional power over adolescent girls, framing it as a protective measure. An African feminist perspective asserts that schools in the county are not bastions of reproductive knowledge, and they intentionally restrict access to such knowledge.

Chapter Two reviewed literature on the influence of government laws and policies in curtailing the advancement of SRH rights. This sub-theme highlighted the discontinuities between policy and practice as well as sociocultural repressive notions regarding sexuality. An African feminist thought reaffirms that colonial systems of knowledge production are evident in the current education system which focuses on producing amenable and asexual adolescent girls. From a reproductive justice perspective, institutions, such as schools and government ministries exercise power over adolescent girls by systematically denying them full access to CSE. This study argues that institutions work in tandem with individuals like teachers who deny adolescent girls access to comprehensive sexuality education. Also, a justice perspective on SRH interrogates systemic factors such as a lack of political will to support the full implementation of laws and policies on SRH. Although access to SRH information is critical to an

adolescent girls' reproductive autonomy, the rights are impractical where there is no functional access to services and socio-economic opportunities (Price 2010).

Based on the tripartite rights articulated under the reproductive justice theory, a violation of the right to CSE impacts on the right to have a child, right not to have a child, and the right to have a child in safe environments. With regards to the right not to have a child, Kohler, Manhart & Lafferty's (2008) study on abstinence versus CSE found that abstinence only curricula did not result to delayed sexual debut, reduction in partners and no reduction in pregnancy rates. On the same breath, CSE was found to delay sexual initiation and increased use of contraception. Thereby, an abstinence only focus in Siaya is practically ineffective.

In reference to the right to have a child under conditions of one choice, scholars like Jewkes et al. (2010) established that girls who lack knowledge about consent, bodily autonomy are more likely to experience nonconsensual sexual debut. Therefore, an abstinence focused CSE that overlooks sexual pleasure and training on consent exposes adolescent girls to reproductive coercion. In relation to the right to parent in safe environments, a Ugandan study by Nalwadda et al. (2010) notes that inadequate SRH knowledge exposes adolescent mothers to repeat pregnancy, reduced education attainment and social marginalisation. Hence, SRH information gatekeepers in Siaya county must take this complexity into account, otherwise adolescent girls would continue to be castigated for individual choices.

#### **4.6.3 Gender and power dynamics**

This study sought to assess the internal and external factors, including gender, which influence ASRH programme interventions by CSOs in Siaya County. The interviews suggested that the marital status of adolescent girls influenced their ability to access information on SRH. For those that were married, spousal consent was paramount, whereas unmarried adolescent girls relied on parents

and carers for decision-making. When asked why spousal engagement was crucial in adolescent girls' decision-making, one participant cited power imbalances in intimate partner relationships.

*“There are issues of power dynamics here. These are adolescents living with their significant others, and issues of decision-making are key. It will inform the kind of involvement that you will have with them so that even the spouses are able to cooperate and give their views. Because if a teen mom is engaged in a programme that her spouse is not aware of, she will not be able to fully participate. There are some of the men who say that their wives are going out to our services, but they don't see the benefit.” Interview with CSO 14*

This finding is consistent with that of Lince-Deroche et al. (2015), who argued that in contexts where adolescent girls had access to SRH information, their male partners interfered with their decision to take-up services such as contraception. This discovery is concomitant with the findings reported earlier concerning the patriarchal traditions of the Luo people whose undergirded social norms dictate that women are under the control of men, as shared below:

*“You realise some of these actions taken by women in terms of even using implants (referring to contraception) are done even without the consent of their partners. Most of it leads to a lot of fights within the household.” Interview with CSO 4*

Chapter Two discussed the role of digital technology in providing SRH information, while Section 4.4.3 above alluded to the role of social media in influencing cultures and socially accepted behaviours in the community, such as early childbearing. This study further found that given the power that men had over their wives and women's submission, the latter could not access mobile phones, as it was a preserve of the husbands, as shared below:

*“It is just how our society is structured and naturally accessing information and accessing services as a woman is very difficult because you need to seek permission; some of them do not even have phones. Some people feel like, for women, that phone is not important. Only when a man's phone is old or repaired will he let a woman use it.”* **Interview with CSO 10**

From a reproductive justice lens, the sustenance of adolescent girls' reproductive control by their spouses, lack of access to information and exposure to gender-based violence infringe on the three rights under the reproductive justice theory. More intently, adolescent girls lack of bodily autonomy indicates that, they cannot negotiate safe sex and plan for a child or access information to facilitate her decision making (Ross 2020).

Realising how key gender politics were at the household level, the researcher probed the participants on how they navigated this challenge. The interviewees revealed that they attempted to promote spousal engagement in their programming as a behaviour change strategy, as shared below:

*“Men not being part of these conversations is a problem, and we are trying to normalise their engagement. For example, there are myths around contraceptives and family planning methods that they fatten women. And even husbands are not allowing their wives to access contraceptives for this reason. Many women still use hormonal contraception in secret, and they tell us that this is because the men believe that it would lead to a low libido.”*  
**Interview with CSO 11**

One participant shed more light:

*“For teen moms that are out of school, there is an element of spousal engagement in any decision that we are making with them. We allow the spouses to be part of the programme; first, we’ll get their views on some of the issues that have been affecting women, such as GBV.” Interview with CSO 3*

The extracts above have indicated that male spousal engagement was a mitigation measure towards ensuring that adolescent girls access the SRH information and services. The review of literature in Chapter Two alluded to gender dynamics within heterosexual relationships in the context of sexual and reproductive health rights. These interviews reaffirmed the connection between intimate partner violence, access to sexual and reproductive health services and information and how those worked against adolescent girls’ agency and body autonomy. From the participants’ accounts, male spousal engagement was a strategy to mitigate male gatekeeping. However, an African feminist scholarship posits that this strategy fails to dismantle male control over women’s bodies. Ampofo et al. (2022) observe that health and development programming in Africa that centre male engagement ultimately sustains the power imbalances they seek to address.

In this study for instance, men exercised reproductive control over their spouses by barring them from accessing contraceptives. It is clear from the CSOs narration that adolescent girls’ ability to engage in SRH programmes is contingent upon men’s approval without which adolescent girls could be exposed to gender-based violence. Mama (2020) challenges CSOs to disrupt these power imbalances as opposed to normalising them. Chakraborty (2021) extend this critique by spotlighting the tendency by CSOs to make men subjects of behaviour change and not agents confronting patriarchal power. Overall, this subtheme correlates to Ibrahim and Shepler (2022) who cautioned against a protection-based programming approach, in this case, adolescent girls security acquired through spousal consent.

The second element around gender and power relations was the plight of unmarried adolescent girls under the care of parents and guardians who played a critical role in decision-making. The quote below shows how the influence of parents and guardians impeded CSOs' ability to deliver on SRH services and messaging:

*“The parents still don’t understand the issue of family planning, especially when you’re dealing with the fathers and the male guardians. Some of them, even with their partners, don’t understand the issue of family planning. Then here you are going to tell them that your 16-year-old girl is already sexually active. You know it does not sit well with them.”* **Interview with CSO7**

Some of the study participants observed that parental engagement was critical in their programming, arguing that parents provided strong social support to adolescent girls, as demonstrated in the first quote. The second quote below, however, outlines a different view of the role of parents in promoting positive adolescent SRH outcomes.

*“We are not working alone; we are collaborating with their parents for those who are still staying with their parents. We are even working with their grandparents. We visit their homes to see what the family support looks like. If the family is in support of what is being done, it really makes our work easier.”* **Interview with CSO 11**

*“Some parents first need to come to terms with the fact that things are not the way they were when they were young. They need to understand that their children need a lot of attention. There is no one else who would take on this role.... they need to sit down with their adolescent children and talk to them. Really talk and share responsibilities. Since we are doing capacity-building with*

*their children, they take a while to understand that there are things that they must do for their children themselves....”*

#### **Interview with CSO 4**

The right to consent paradox was discussed in Chapter 2, and this finding elaborates how, the law and adolescent girls' SRH needs are not in tandem. Whereas parents or guardians are legally mandated to make SRH decisions for them, the state fails to protect them from sexual pressure and coercion. From a reproductive justice lens, this amounts to a political move to control adolescent girls' bodies under the guises of protection (Ross 2020). Literature reviewed in Chapter Two revealed the centrality of parental engagement as articulated by the *Kenya National Adolescent Sexual and Reproductive Health Policy (2015)*, which envisions that the government would work collaboratively with communities, parents and civil society organisations to achieve its policy objectives. Parents emerged as a source of SRH information, although they were critiqued as being focused on abstinence, whilst other studies found that adolescents found them unfit as sex educators (Ayalew et al. 2018; Lince-Deroche et al. 2015;). This study revealed the tensions around parental engagement, from a protectionist versus justice perspective. Noticeably, the CSOs engaged them for legal expediency and protection of the girls in general yet Varadan's (2019) evolving capacities principle were silent.,

#### **4.6.4 Limited access to contraceptives and SRH services**

From this study, it emerged that limited access to contraception was a barrier to adolescents' reproductive justice in Siaya County, corroborating the literature review in Chapter Two. The participants identified institutional factors such as stockouts in government facilities discussed in Section 4.5, which, as the first quote below demonstrates, was linked to a national supply chain challenge. From a human rights standpoint, the government, as a duty bearer, has the mandate to respect, protect and fulfil adolescents' SRH by, among other things, resourcing contraception and related services (Buller & Schulte 2018).

*“The supply of contraceptives in our health facilities is still not adequate to sustain the needs of these girls, and so it’s very important that county government increase their allocation towards SRH.” Interview with CSO 6*

Another participant indicated:

*“Another gap is contraceptives. We are trying to push on the issue at the county level, but when we discuss this with the county, we are told that it is a countrywide issue”. Interview with CSO 2*

Prolonged access to contraception is a reproductive justice issue and directly impacts on an adolescent girls’ right not to have a child, however, CSOs in the county must name this as a governance gap (Ross & Solinger 2017). Morison (2021) avers that reproductive justice must be depoliticised more, so when governments are failing to provide contraception. Not only should the CSOs be the voices demanding for contraception, but a reproductive justice lens also requires that adolescent girls are at the centre of this agitation.

Another institutional reason identified by the study participants was the lack of diversity of contraceptives to cater to adolescent girls’ preferences, as shared below:

*“I remember that recently I was having a session with the young girls, and one of them said that she went and was given an injection, and they gave her the brand that was available. She was bleeding until her husband was like - These days you bleed 24 hours. So, she discontinued, but no alternative was offered to her.” Interview with CSO 11*

The failure by government to provide the required contraception, at the term it was required and appropriate care when challenged with a reaction is termed as structural abandonment by Brunson & Senderowicz (2019). A justice perspective demands that an adolescent girls' body is not managed as an afterthought but rather carefully supported with the highest quality of care as envisaged by laws and policies on SRH and broader human rights. Furthermore, most participants stated that the issue at hand was not just the absence of contraceptives but also a lack of knowledge on how to use them, as shared by a participant below:

*“There's a big demand for contraceptives, but something that is very concerning is that there are a lot of barriers to their use and information. And this is because Siaya is a rural county; you realise it's only a few people who understand the different types of contraceptives available. But even when you go to the facility, some of the challenges that we can see are the lack of information about contraception, with people using it; you realise they do not understand how different methods work.”* **Interview with CSO 2**

As discussed in the previous subsections a transfer of structural and institutional failures on individual girls takes away accountability for from the state and advances neoliberal logics in development. This simplifies complex SRH matters to simplistic technical problems that could be restored by information sharing (Rose 1999). A reproductive justice lens contends that the lack of knowledge on how to use contraception is a systemic failure that promote women's bodily oppression.

These statements above have exemplified how institutional and individual factors intersect to deny an adolescent girl access to her SRH rights. A major tenet of reproductive justice theory is intersectionality, which emphasises that SRH services must be responsive to and acknowledge the needs of excluded and marginalised women, in this case, adolescent girls (Johnson-Mallard et al. 2024).

Participants indicated that access to SRH services was hindered by issues around client-friendly services; in particular, the interviews foregrounded concerns about service providers who were not friendly to young people. The researcher asked the participants to explicate the nature of unfriendly services for adolescent girls, and the responses on this issue revealed that health service provider negative attitudes and lack of privacy during advice-sessions. Regarding health service provider attitudes, participants complained that some of the adolescent girls they worked with were treated with contempt and shamed as they sought access to contraception, as shared below:

*“Sometimes when these girls go to seek some of these SRH services, there’s no youth-friendly service provision at this point. So, they tend to shy away because they get intimidated and the language used there is not friendly to them. They feel that they are sinners already or that they are criminals.”* **Interview with CSO 7**

This view is supported by the ideas expressed by Chimatiro et al. (2022), who found that individual factors were at play, especially where adolescents lacked confidence or were embarrassed due to fear of reprisal from health service providers. Similarly, the capacity of health service providers to deliver SRH services to young people was identified as a challenge. Specifically, interviewees felt that some older health service providers held prejudicial and biased views when serving young people, as described below:

*“The older people consider them as their children. So, they act like parents, so when somebody wants a contraceptive, a mama in the facility will say, ‘You’re still young; why are you doing this? You are not supposed to use family planning. Which family are you planning?’”* **Interview with CSO 5**

Likewise, this study revealed that intergenerational attitudes between adolescents and older health service providers posed a challenge to the full enjoyment of SRH services. The quotes below demonstrate this:

*“Most of the health facilities, when you get there are those old nurses or doctors. So, getting these old doctors to understand an adolescent girl becomes very difficult. Then adolescents see themselves as kids having to tell an old woman their issues.”*

**Interview with CSO 2**

*“This is what they ask for; they need a place where they just go, and the people who are serving them are not those very old mature women or nurses. I know of a girl that shared her experience going to seek services, and that nurse knew her mum. She feared that the nurse was going to tell her mom, so she changed her mind and changed the story because the nurse was going to expose her to her mom”.* **Interview with CSO 11**

The participant accounts on health service providers shaming, intimidating and moralising adolescent girls at the health facility is tantamount to reproductive violence and not just a personality clash. Daigle and Spencer (2022) pinpoint how power threatens inclusion and pushes marginalised populations further to the periphery. Hostility from public health facilities, using the authority of public office to police adolescent girls' reproductive choices, is a well-structured mechanism that blocks adolescent girls' reproductive justice.

Health service providers emerged as reproductive gatekeepers whose approach moves beyond technocracy, that is, lack of a technical skill. They reflect how adults are equipped by their institutions to adjudicate adolescent girls' reproductive choices. Tamale (2011) tracks this back to the combination of andropatriarchy and colonial health system. Where patrilineal authority

converged with colonial health system hierarchies in East Africa. Hence an older health service provider at the facility level reproduces an institutional logic that situates adolescent girls' reproductive choices as subject to adult moral confirmation. Reproductive justice demands that this reasoning is recognised as a governance failure, not an individual's negligence.

The quotations above are consistent with Geary et al. (2015), who found that YFS was not available due to staff incompetency, specifically behaviours and attitudes that impacted negatively on young people's clinical experience. Godia et al. (2013) observe that health service providers are significantly influenced by their personal beliefs, failing to respond to the needs of adolescents. As suggested in the last quotation, lack of privacy was reported as a stumbling block to accessing contraception and SRH services. This current finding is congruent with Onyando et al. (2018), Ahinkorah et al. (2021) and Msuya (2019), who observed that the infrastructural design of health facilities have an impact on the effectiveness of youth-friendly services, with young people preferring locations with easy access and with an acceptable level of privacy. The excerpt below outlines a participant's perspective:

*“There's a lack of privacy when they go to seek these services from the public health facilities; you realise that, for example, some of these services are next to a maternity ward. I mean they are not secluded in such a way that an adolescent girl can just walk in, be served and walk away. She must wait in a long queue, or she must go through some processes within the facility that are not friendly. And so then, they tend to shy away.”* **Interview with CSO 7**

It is evident that the health facility ecosystem contributes to adolescents' choice to access contraception. CSOs do make crucial steps towards ensuring access to family planning commodities, via budget advocacy, but there was limited

evidence of them advocating, as a collective, to change health systems by strengthening infrastructural development or human resource development.

Adolescent sexual and reproductive health rights include the right to health, which covers access to abortion services. One of the objectives of reproductive justice is to promote the right of women not to have children, via use of contraceptives and the elective termination of a pregnancy. Most participants did not include any abortion-related services in their organisations' programming, either through advocacy or via service provision. In an interview with a CSO that provided SRH services, it was clear that they did not provide abortion services under any circumstances:

*"In Kenya, abortion is generally illegal. But there are those who are practising it either medically or backstreet using abortive herbs. But at the facility we do not encourage abortion. Personally, I will make sure I tell you the benefits of having the child rather than terminating it. Because terminating is even riskier.... you might bleed to death, or you might get sepsis. So, it is easier for you to carry the baby to birth, and then afterwards, now we have a deeper discussion on why you need to wait longer until you're mature enough for you to be able to raise a child."*

**Interview with CSO 6**

The vignette above demonstrates how health service providers' personal values and biases impede on adolescent girls' bodily autonomy. Kapur (2002) posits that feminist and development discourse that positions women as victims needing guidance reinforces paternalism and undermines rights claims. In this instance, the health service provider took a protectionist approach and assumed the position of a custodian of an adolescent girls' reproductive life. Fundamentally, a reproductive justice lens to SRH maintains that the adolescent girl is the rights holder whose bodily autonomy and agency must be prioritised not donors, health service providers or government.

Another study participant who worked on advocacy indicated that they attempted to talk about abortion rights in some spaces, but the government was against it, as shared below:

*“For the CAC and PAC... even though the government is against it... at least we are trying to push it. What the government is against is us exposing these young people to these so-called ‘dirty things’”. Interview with CSO 1*

The researcher also sought to find out whether access to abortion information and services was part of their SRH information package. In response, most CSOs reported that they were unable to engage with abortion issues given the social stigma and possible fear of reprisal. The excerpt below illustrates the complexity in delivering abortion-related information:

**Researcher:** *“Are you able to, for example, talk about HIV, sexually transmitted diseases, and abortion rights? Can you deal with all of these?”*

**CSO 4:** *“We focus on STIs. We talk about personal hygiene, and when we do community sensitisation, we also talk about HIV and AIDS. We don’t talk about abortion for now.”*

**Researcher:** *“I understand, however, SRH is broad-based and has many components to it. Is there a particular reason why abortion is a no-no?”*

**CSO 4:** *“No, it’s not that it’s forbidden. We simply have not been able to talk about it.” Interview with CSO4*

The evasion in the reply was obvious, and the research participant changed the conversation away from abortion. This indicates that full reproductive justice for adolescent girls is not on offer because the services exclude information on comprehensive abortion care. Key to this was the low levels of understanding around legal provisions and legal grounds for abortion services in Kenya. Article 26(4) permits abortion where a trained health professional determines that the life or the health of the mother is at risk. Most recently, the high court pronounced itself on the application of this article in the case of *PAK and Salim Mohamed vs. Attorney General*, indicating that arrest of a patient seeking services and a health provider offering those services is illegal. Further, in the case of *JMM vs. Attorney General*, the High Court expanded the definition of health as articulated in Article 26(4) declaring that a pregnancy resulting from rape constitutes a danger to the physical and mental health of the mother. Increasingly, court rulings have invalidated administrative policy positions that state agencies and medical boards have used to circumvent the constitution. For instance, in 2024, the High Court nullified a clause in the *National Reproductive Health Policy 2022-2032* which referred to the prioritisation of an unborn child's health before termination.

The profound silence around abortion in CSO programming warrants scrutiny through an African feminist lens which elevates the matter beyond social stigma and limited legal knowledge. Tamale (2011) posits that abandonment of abortion rights represents a continued reproduction of colonial sponsored patriarchal control over women's bodies. Therefore, a CSOs inability to engage this discourse reproduces the knowledge and systems that systematically disempower adolescent girls and throttle their right to SRH. (Ekine & Abbas 2013).

This subtheme exposed CSOs insularity on abortion, and given the tensions around CSO workers personal values, stigma around abortion matters, information gap seemed wider (Juma et al. 2024; Ouedraogo et al. 2024; Mohamed et al. 2018). By CSOs caving to social stigma and government control

on abortion, they risk enabling reproductive oppression. ultimately, working against their core constituency, adolescent girls.

#### **4.7 DEVOLUTION OF PATRIARCHY: CHALLENGES IN THE IMPLEMENTATION OF POLICY AND LEGAL FRAMEWORKS**

One of the research objectives was to interrogate the influence of policies and laws on CSOs' engagement with ASRH in Siaya County. From the vantage point of reproductive justice, identifying those systemic, individual and communal factors that impede the implementation of ASRH is crucial. Nduna et al. (2017) report that the abundance of laws and policies around SRH in Kenya does not translate into acceptable implementation due to political and socioeconomic factors. This theme identified gaps around the implementation of policies and laws on adolescent sexual and reproductive health in Siaya County based on the participants' programming experience. From the interviews, three factors emerged as being challenges around the implementation of policies and laws on ASRH, namely, low political commitment and leadership, insufficient funding and budgetary allocation and lack of domestication of policies and laws at the county level.

##### **4.7.1 Low political commitment and inadequate leadership**

Oronje (2013) points to a lack of political will to implement a rights-based sexual and reproductive health agenda in Kenya due to morally contentious issues such as abortion rights. Similarly, this study revealed that some political leaders in charge of implementing policies on sexual and reproductive health acted based on their personal values rather than following the spirit of the policies and laws. The quote below outlines a participant's perspective:

*“The county is very good at developing policies but very poor in terms of implementing them.... You meet different decision-*

*makers who have their different values, norms, and beliefs, which then affect the implementation of the policies.” Interview with CSO 5*

The vignette above points out that decision makers implement adolescent SRH policies based on their personal preferences and values. Ross (2020) observes that the foremost challenge in reproductive justice advocacy is that political and decision-making power rests with actors that are insulated from accountability to the adolescent girls in Siaya county as the primary rights holders. Therefore, reproductive justice theory provides a movement building framework where disenfranchised rights holders through their collective power put duty bearers to account. African feminist scholarship places low political commitment within the context of post-colonial state formation where African states regularly utilise legislative frameworks and moral discourses to restrict women and girls' reproductive autonomy (Mama 2020). As such, political leaders' decision to implement ASRH policies from their personal norms, values and beliefs can be viewed as an intentionally orchestrated process.

While the laws of Kenya, including the constitution, are clear on the right to health for all, there were discriminatory and exclusionary practices against persons of diverse sexual orientations (Nduna et al. 2017).

The extract below shows a participant's perspective:

*“We have an article that speaks about the highest attainable standards of health in Kenya, Article 43, but we still don't recognise the other key populations or the LGBTQIA+. These are some of the contradictions that we are having as a country, but also the understanding of SRH at national and county level.” Interview with CSO8*

A reproductive justice perspective to SRH contends that human rights are indivisible, hence Article 43's guarantee of the highest attainable standard of health must be enjoyed by all. Consequently, the non-recognition of key populations' SRH needs is a function of political defiance and not a technical implementation gap (Morison 2021).

The researcher asked participants to suggest ways in which the lack of political commitment was demonstrated. In response, the interviewees mentioned frequent stagnations in the policy process as outlined below:

*“I think the problems lie at a structural level. We can push issues from the grassroots, but when it gets to the top, there's always something that makes that momentum stagnant. Like the gender policy we created as a Gender Sector Working Group. It was supposed to go to the County Executive Committee members; I don't know how it evolved.”* **Interview with CSO 12**

The narration above illustrates some of the challenges that participants experience in their role as advocates for SRH-related policies. What this study shows is that, in as much as CSOs collaborated with government entities on the development of policies, they were not in control of the end processes and product. The lack of traceable accountability on policy development processes that CSOs collaborate with the government on reflects a significant structural indictment of the devolved governments architecture. This finding exemplifies the implementation of the shadow state within the Kenyan system (Wolch 1990). Findings from this subtheme demonstrate how CSOs perform governance roles through policy development and engagements in technical working groups. What's more, the state appropriates this as evidence of its responsiveness, whilst CSOs engagement supports state inaction.

The participants also indicated that a lack of political commitment was displayed through a lack of clarity and accountability around the implementation of SRH-

related policies. As discussed in Chapter Two, Kenya shifted to a devolved system of governance in 2013, where two levels of government were created: national and county level. A framework for health governance was enshrined in the *Kenya Health Policy 2012–2030*, where the national government was mandated to create policy and perform regulatory functions, whereas counties held responsibilities for planning, budgeting and management (Nyawira et al. 2021). The quote below outlines a participant’s perspective on health governance:

*“There’s a big disconnect between the two levels of government that is the national and county government. I think this is more in terms of how policies are supposed to be cascaded. When you’re speaking about comprehensive sexuality education, you realise they have very divergent views. For example, the attitude of the Ministry of Education is quite different from that of the Ministry of Health. The issues around bureaucracy within these levels of government are one of the hindrances to implementing these policies at the county level.”* **Interview with CSO 8**

Another participant indicated that there was a disconnect between policymaking at the national level and actual implementation at the county level. To him, there was a lack of accountability, making it challenging for SRH policies to be implemented, as demonstrated below:

*“Sometimes we find that we have the laws at the national level, but then there is no implementation on the ground. Because when I am talking about accessing the highest attainable standards of health, then that also means that information is part of access to health. When you reach out to the government officials, the health people, the Teacher Service Commission, or the Ministry of Education, it is always a turnaround. This person says it is not our responsibility. Some of the teachers have*

*indicated interest, but we cannot because the Ministry of Education does not allow comprehensive sexuality education in schools. It is like a continuous web; I cannot do this because of this... but we also cannot do this because of another thing. They keep pointing fingers at the other party, and it goes on and on.”*

***Interview with CSO 10***

The situation presented in the excerpts above bring two issues to the fore, one, the benefit of confusion to the state, the Ministries of Education and Health differ on how to engage with CSE. Schaaf et al. (2022) proffers that by failing to narrow responsibility of implementing SRH policies then the state creates an accountability vacuum. Two, when CSOs are pulled into technocratic and administrative government processes, their social justice mission is depoliticised. These types of activities keep the state engaged, but engagements never respond to their main constituencies' needs (Hearn & Lavers 2022)

It emerged from the interviews that poor coordination and low accountability between the two levels of government in Kenya impacted the full realisation of adolescent SRH rights, a view that was also expressed by Abdi et al. (2023). There are challenges with government bureaucracy at the county level, however a participant indicated that there were selected policymakers who have become strong allies in the SRH cause at the county level, and that their support is critical in promoting sexual and reproductive health and rights, as demonstrated below:

*“And right now, we have within the Health Department a Chief Officer who is very proactive on issues of health, and I mean really that’s an opportunity for this government in the next few years. He can transform issues around SRHR and services in this county. In our advocacy work, those are the kind of individuals that we target with our message and what that can influence at the Cabinet level and even at the Governor’s Office level, so that things can just change.”* ***Interview with CSO 7***

The vignette above demonstrates that although individual support for the SRH agenda is critical, it is not enough to sustain the systemic and longer-term shifts required. Moreover, reliance on individual staff as champions symbolises a lack of structural accountability, placing a burden of change to individuals that operate in patriarchal bureaucracies. Staff transitions at the county Department of Health destabilises SRH-related processes, and as a result, SRH stakeholders are forced to restart processes. The quote below represents a participant's view:

*“The transitions at the county level always destabilise different actions because we are not just looking at activities at the county level but also at facilities. This affects the composition of the County Health Management Team, the County Health Committees, and the facility managers we are working with.”*

***Interview with CSO 8***

Additionally, the researcher sought to understand participants' perspectives on the impact their engagements had on policymakers in the county. The participants acknowledged that the government's commitment towards sexual and reproductive health rights was wanting, underscoring the need for CSOs in safeguarding the space, in line with the constitution. The quote below shows a participant's perspective:

*“Were it not for these CSOs and the partners, reproductive health could have been something of the past. It is the government that is a blocker because you realise there is this reproductive health policy, the one which was signed without the consent of the citizens. Which, of course, it is still in court. How can you pass a law without the participation of the stakeholders who are the community members?”* ***Interview with CSO 1***

A reproductive justice point of view stresses the full understanding of the stumbling blocks for the full attainment of adolescent SRH. Policymakers and implementers are easily caught up in bureaucratic issues that prevent implementation despite the existence of liberal laws and policies.

#### **4.7.2 Devolution of national policies to the county level**

As discussed above, the devolved governance structure in Kenya places policy-making responsibilities at the national government while planning and budgeting are at the county level. Most of the research participants pointed out that the absence of policies at the county level hindered budgetary allocations which are crucial to the implementation of SRH policies. The excerpts hereunder demonstrate the connection between the existence of policies, planning and resource allocation.

*“The challenges at the county level are that we do not have very comprehensive policies, unlike at the national level. And so, the county says they must domesticate. When you are advocating for an issue, you must check whether there is a policy. If there isn't, then you must start at the policy level. For example, you find that when we were advocating for a rescue centre for gender-based violence survivors, we did not have the policy on protection against gender-based violence. We had to advocate for that to be established first.”* **Interview with CSO 10**

*“We realise that apart from having issues with what the county can support within its different budget allocations, there is a lack of legal frameworks that make it difficult to engage in terms of resource allocation for particular areas that need to be focused on.”* **Interview with CSO 8**

The study participants recognised the role of policy and legislative frameworks in general, however, one participant disagreed with the idea of a lack of policies, arguing that policies and laws were sufficient, but that monitoring of their implementation at lower levels of governance was the real issue.

*“We have a lot of laws; the biggest thing is implementation. Yes, I know that some bits of these policies need to be reviewed, like standards and guidelines, and they are looking at this [meaning national government]. Today, if I walk to Siaya County and ask them if they have a family planning cost implementation plan, one that is specific for adolescent SRH and for HIV...or if I ask them what has been implemented to date... then no one knows. You see?”* **Interview with CSO 9**

A reproductive justice lens to SRH posits that legal guarantees are insufficient in the promotion and sustenance of SRH rights in the absence of functional governance structures (Sister Song Women of Color Reproductive Justice Collective 2007)). Thereby, instructing CSOs to engage in foundational policy work moves them away from their core job, and they also end up doing the states' work.

The researchers' participants indicated that the government's failure to allocate budgets towards the implementation of SRH policies curtailed the implementation of SRH policies and legislations as outlined below:

*“In addressing the financial support from the county, we are at least trying to do some memos. We are trying to push for financial support; at least they allocate good money to the Ministry of Health so that most of these services are available. But then at the level of a facility, you realise that the idea of youth-friendly centres was supposed to feature at each health facility. Now, the government was arguing that because the nurses have been*

*trained on such, establishing youth-friendly centres is not needed....” Interview with CSO 13*

These findings are reflective of the status of health governance in Kenya post-2013, when devolved governance was implemented, delegating political authority, fiscal and administrative issues related to health to the county governments. The excerpts above aligned with the work of Muthui (2022), who analysed the challenges of devolution as leading to poor priority-setting, with politicians favouring those causes that gave them greater visibility or that offered channels for the misappropriation of funds via procurement. Hussein et al. (2021) have shown that critical elements in health management, such as the provision of community health services, have failed to materialise because of incomplete legislative and policy-making processes at the county level.

Taken together, findings under this subsection have identified devolution as a new site of patriarchal resource capture where public budgets reproduce gendered exclusions. The findings above describe a dysfunctional system that is managing, containing and suppressing adolescent girls' reproductive autonomy.

#### **4.8 NGOISATION: OPERATIONAL AND FUNDING CONSTRAINTS FACED BY CIVIL SOCIETY ORGANISATIONS**

One emergent theme from the data analysis was the challenges faced by civil society organisations in the deployment of their mandate. This theme responds to the research question around factors that influence CSOs' implementation of adolescent sexual reproductive health interventions and an exploration of how they navigated their challenges. This theme, resulted in the emergence of the following sub-themes: legal restrictions, funding, power relations and competition among CSOs.

#### 4.8.1 Legal restrictions

Chapter Two explored the challenges facing civil society organisations where governmentalism was identified as a barrier to their engagements. In this study, governmentalism presented itself in the form of laws, policies and administrative actions that CSOs had to comply with to be in right standing with the government. Glasius et al. (2020) observe that governments use policy and legislative frameworks to muzzle the voices of CSOs. This study found that legislations under which CSOs were registered determined their geographic footprint, yet SRH issues are transboundary. Section 4.2 discussed the registration typology of the CSOs interviewed and concluded that the type of registration impacted the organisations' ability to deliver on their mandate.

Matelski and Woensdregt (2024) observe that registration assured the legitimacy of local CSOs engaging in advocacy at the grassroots level so that government and communities would find them more credible as entities. This study found that the type of registration that a CSO held influenced their geographic footprint and the extent to which they could implement their mission of improving adolescent sexual and reproductive health in Siaya County. To illustrate how registration status related to geographical reach, the following quotation describes the correlation between registration and geographic footprint

*“We're a community-based organisation, so currently on matters to do with sexual and reproductive health and rights we're working in Alego Usonga in North Alego Ward and Southeast Alego Ward, and we are also working in Bondo Sub - County in West Yimbo and also West Sakwa.” **Interview with CSO 13***

*“We cannot go beyond the county. Sometimes you wish to work outside the county, but it's not easy. We are registered under Alego Usonga. We cannot work beyond Siaya County. That is a*

*restriction from the certificate for the registration.” Interview with*  
**CSO 2**

The finding under this subtheme reaffirms other studies where, because of neoliberalism, CSOs as collectives are legitimised by legal frameworks, and relevant actors strive to remain accountable to the regulators (Girei 2023; Kamstra 2020). The findings above demonstrate that governmentalism is an act of colonial and patriarchal control (Banerjee & John 2025). Specifically, African feminists contend that SRHR issues transcend boundaries and are rooted in shared patriarchal struggles, therefore, by containing a CSOs work to their registration, the state deters cross county movement building (Tamale 2020). When a CSO derives its legitimacy through compliance with government, their downward accountability to adolescent girls in Siaya County is compromised as it undermines their ability to be radical in their engagements (Kumi 2021).

#### **4.8.2 Funding**

Civil society organisations are impact-driven by design and vastly dependent on donor funding (Gachenge et al. 2021). At the same time, donor support towards CSO work has been dwindling over the years for a myriad of reasons, including a shift in donor priorities, which has left many civil society organisations financially unstable (Iye & Akinpitan 2023). Section 4.2.3 discussed the funding typology of the study participants, where it was indicated that they funded their programme interventions through donor funds, short-term partnerships with other CSOs and voluntary human and financial resources. Participants in this study, regardless of their funding sources, indicated that a lack of funding was a major impediment although some stringent standards are prescribed by donors; for instance, donors were said to prescribe the number of years a CSO had been operational as a prerequisite for funding support, as highlighted below:

*“Most donor specifications when it comes to advocacy require that you must be strong on the ground. And being strong means*

*that you must have been in existence for more than two years. So, for our case, we have been applying for funds, but now they are putting us on a pending list.”* **Interview with CSO 13**

In addition to the requirements around the years of operation, another participant indicated that some donors required that civil society organisations demonstrate experience in managing set amounts of funding, as shared by the following vignette:

*“Then another challenge that we are facing is the way you’re writing a proposal for funds... they say that we want an organisation that has done this and this. They need an organisation that has implemented more than five years; they need an organisation with an account that can handle more than millions, yet our organisation cannot do that. So, you get that most of the proposal opportunities leave us far behind.”*

**Interview with CSO 2**

The findings above reveal how managerialism presented in the respondents’ experience. By demanding that CSOs have a specified number of years of experience and financial management capacity the finding reveals how the patriarchal aid architecture, privilege elite organisations as opposed to girl led grassroots collectives.

These findings on donor rules and regulations are consistent with Erdilmen & Sosthenes (2020) and Mulder (2023), who observe that local CSOs found it challenging to access donor funding due to rigorous requirements. Related to this, in instances where CSOs had already accessed funding, participants argued that donor funding confined them to piecemeal interventions, yet adolescent sexual and reproductive health issues are complex and require longer-term and intersectional interventions. The quotation below explains:

*“We are only able to address one issue at a time, and you leave out all the other intersecting issues that lead to this one issue. And this is because of the inadequacy of resources. For example, if you are talking about a girl who is in school, I’ll meet this girl in school, and I’ll give her the information, but then again, even if she went to a facility to access services, she might not have the money to travel there. The question is, even when we create interest in services, do the girls have the money to facilitate their access? An individual never only has one problem.”* **Interview with CSO 10**

The participants’ experience above demonstrates how donors’ perspectives and programmatic focus rejects intersectionality. By compelling CSOs to address adolescent girls’ singular issues, they fragment the needs of a girl and support singular problems.

The participants noted that the primary impact of low or non-existent funding was their inability to deliver on their programmes and overall organisational sustainability. The quotations below outline the participants’ perspective on programme delivery.

*“You know donors come in and go, like from 2019; I think due to COVID, most of the donors didn’t really come out to support most of the programmes. Some of them pulled out. So, most of the programmes nearly came to a halt.”* **Interview with CSO 16**

*“Our scope remains limited, informed by limited resources, and that we just look at what those high-impact activities are that can be resourced and be done. Second, of course, tied to that is looking at how we can be able to diversify our donor funding so that we have more resources coming our way and we are able to continue discharging our mandate.”* **Interview with CSO 9**

Similarly, inadequate funding negatively impacted the CSO's organisational capacity, particularly retention of staff, which is a critical element of programme delivery, as shared below:

*“You know, at times we’ve finished the funding, and then someone says, like, no, I can’t stay here. I need to find greener pastures somewhere. Then someone new comes in, and you take the person through orientation till they are well caught up. It is difficult work. So that’s a big challenge we face as an institution.”* **Interview with CSO 12**

*“One of the major challenges is inadequate resources. You know they also are in the form of the personnel. We know that with the inadequate resources; we are not even able to address most of these issues in terms of providing the services and facilitating the teen moms.”* **Interview with CSO 14**

Participants raised sustainability as an issue due to the short-term funding, as demonstrated below.

*“Some of the challenges that we all face as an organisation in terms of our programming are sustainability, which is linked to financial resources. Some of the programmes that we’ve been able to implement have been short-term.”* **Interview with CSO 3.**

The financial instability experienced by the participants above demonstrate how the funding architecture exposes them to unequal power dynamics with the donors who hold their organisational lifeline. Byaruhanga (2026) argues that donors use stringent requirements to depoliticise social movements, turning them into grant managers and not transformative social change makers. This study has affirmed that even though the aid sector has continuously promised that

localisation would open financial opportunities for local CSOs, rigorous financial and grants compliance requirements block their access. This divergence in aid rhetorics and practice is resonant with African feminist thought which contends that local CSOs operate colonial hierarchies which block their social justice mission (Tamale 2011). Likewise, neoliberal language adopted by the CSOs such as implementation of high impact activities shows how adolescent girls' lives were pitched as products to attract funding.

These findings above related to the influence of donors on adolescent SRH programmes agree with those of Rao (2023), who argued that local and national CSOs face programmatic and operational challenges due to short-term project-based funding models and strict donor compliance requirements. The work of civil society organisations is highly dependent on donor funding, as observed by Anheier (2017) and Walton et al. (2016), who indicated that the financial operating environment for CSOs has been increasingly challenging. Overall, not only does the donor aid architecture underfund CSOs, but it also re-engineers what they can see and respond to.

#### **4.8.3 Competition and duplication of efforts among CSOs**

Another challenge identified by the study participants was competition among CSOs in their areas of operation. Most of them conducted similar project activities, targeting the same communities and often resulting in a duplication of efforts. The quotation below shows an example of how competition presented itself:

*“The biggest challenge that we are facing, is you get a young woman living with HIV, sometimes she’s in a certain CBO as a community champion, and you want to engage her. Then you get a fight between two organisations; they ask, why are you taking our women? Why are you taking our adolescent girls? Why are you taking our SRH providers?” **Interview with CSO 2***

This finding showcases how CSO engagements mirror colonial logic where adolescent girls' lived experience is commodified by an organisation for its survival.

In addition, whilst the CSOs interviewed were implementing ASRH-related projects, there were differences in the operational capabilities between smaller CBOs and larger CSOs with regards to how they engaged stakeholders, especially service providers and government. According to the study participants, CSOs provided financial allowances to stakeholders during the implementation of project activities. Meanwhile, the amounts to be shared with stakeholders were determined by the individual organisation based on their policies and financial capabilities. Unfortunately, smaller CBOs lacked the financial muscle to match the larger CSOs, and this made it challenging for them to engage stakeholders effectively, as demonstrated below:

*“When you are calling for a meeting, few will come. The big boys, as we call them, pay a service provider differently from the way a CBO will pay. So, you get a challenge when you want to conduct an outreach within their facilities; they always ask you - how much you will pay us at the end of the day? Sometimes we tell them that our policy is only 500. Then they tell you that no, we are used to 2500; this is a CBO; it can't do 2500.”* **Interview with CSO 7**

The extract above shows how competition for resources erodes African feminism where collective care and wellbeing is prioritised. The use of 'financial muscle' shows how hierarchical patriarchy plays out among civil society organisations. Lokot et al. (2024) argue that when larger entities use their financial prowess to influence development processes, they make it challenging for grassroots organisations to operate.

Koch and Rooden (2024) and Matheka and Nzomo (2023) found that competition for funding and financial resources is commonplace among civil society organisations. What this study has illuminated is that competition among CSOs expanded to competition for programme stakeholders, including service providers and participants. This is further compounded by individual CSOs' financial muscle based on the nature of the funding portfolio they hold. Similarly, participants identified duplication of efforts as a challenge impacting the delivery of their mission. The participants indicated that they worked in the same communities, implementing similar activities because of inadequate coordination and competition for resources. This competition was attributed to a lack of coordination among actors and donors' requirements, as demonstrated below:

*“We can also speak of actions that are duplicated by different partners working in the same areas. I think this is kind of a lack of information around what different partners are implementing, because I think one way of mitigating competition around similar actions is building synergy....”* **Interview with CSO 8**

Upon inquiry on how the participants navigated competition for resources, they indicated that they coordinated with other CSOs via the Siaya Health Network for synergies as identified below:

*“We may not have funding as an organisation or as an entity, but we're part of a civil society network within the county, which would mean that sometimes certain organisations have some sort of funding, and then, for those without funding, we can always leverage it. So, partnership has also contributed to enhancing the sustainability of some of these activities.”* **Interview with CSO 7**

*“We're also cognisant of working with the youth and women's organisations in SRH, and then I'll be practical around this by*

*saying that we also work with the Siaya Muungano but under a network that now brings all the stakeholders together.” Interview with CSO 8*

The findings around competition for programme stakeholders, including programme participants, can be attributed to donor rigidity and technocratization of programme design, which often takes a linear path with limited room for adaptability (Gutheil & Koch 2023). Even though this perspective did not emerge from the study findings, literature reviewed in Chapter 2 alluded to the fact that the aid architecture is anchored on neoliberal ideals that propel professionalisation, project effectiveness and quantified impact; a reality that is far removed from the materiality of social change (Gutheil 2020 & 2021). The impact of this dogmatism is CSOs' inability to be flexible and adaptive in their programmes, given the stringent measures and performance indicators agreed upon with donors (Gutheil 2020).

Power dynamics and competition among civil society organisations can be complicated because these groups frequently work in related fields, and their objectives and missions can occasionally result in both cooperation and conflict. The shared objective of these organisations is promoting the public good, however, several variables lead to power conflicts inside the industry as well as rivalry from both the outside and within. Result from this study show that competition for resources and stakeholders impacted the organisations' operations. This concurs with Lokot et al. (2024), who posited that the hierarchies in the development and humanitarian architecture leave local CSOs disempowered.

#### **4.9 CONCLUSION**

This study has demonstrated a consistent and structurally coherent pattern: the systematic depoliticisation of adolescent SRH work in Siaya County through the interlocking operation of state integration, donor logics, state compliance and the

internalization of neoliberal programme logics by CSOs. The programme interventions implemented by CSOs revealed how donor-driven programming reduced adolescent girls' complex, intersectional realities to linear, measurable, and fundable problems. Policy advocacy demonstrates how CSOs' engagement with government processes is structurally guided into invited spaces that the state controls and can abandon without consequence. The barriers to reproductive justice depict how sociocultural, institutional, and political systems work in tandem to deny adolescent girls the tripartite rights that reproductive theory pronounces, while simultaneously transferring responsibility for navigating those systems onto individual girls.

The implementation challenges around policy and law demonstrate how the state benefits from the confusion it produces, by using CSO engagement as evidence of collaboration and partnership while retaining the power to determine what is implemented. Besides, the operational challenges facing CSOs reveal how their legal, financial and competitive ecosystem reproduces the very hierarchies that their social justice mission commits to dismantling.

The dynamics outlined herein affirm that the system is functioning as designed. A post-colonial African state that was never restructured to centre women's and girls' reproductive autonomy, a donor architecture anchored in neoliberal development logics that privilege quantifiable output over structural transformation, and a legal and regulatory environment that contains civil society within boundaries of government-defined legitimacy. Cumulatively, these factors present an environment where adolescent girls in Siaya County are managed as vulnerable victims rather than rights holders.

In conclusion, a feminist lens to adolescent SRH posits that disrupting this condition demands more than better coordination, increased funding, or fidelity to policy implementation (Mama 2020; Ross 2020; Tamale 2011). It calls for a fundamental re-politicization of the adolescent SRH agenda that is grounded in African feminist epistemologies that generate knowledge from the lived realities

of adolescent girls in Siaya County. A reproductive justice lens argues for social and political change processes that are driven by adolescent girls as a collective.

## **CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS**

### **5.1 INTRODUCTION**

This study sought to establish civil society organisations' contribution to the realisation of adolescent reproductive justice in Kenya. Firstly, the study assessed the internal and external factors that influenced ASRH programme interventions by civil society organisations. Secondly, the study evaluated the effectiveness of the strategies deployed by the CSOs. Thirdly, the study interrogated the influence of political, socioeconomic and sociocultural factors, policies and laws on civil society organisations' engagement in adolescent reproductive justice. Finally, based on the findings, the study aimed at offering recommendations for the realisation of adolescent reproductive justice in Kenya. These research objectives were explored through three research questions:

- To what extent has the robust policy and legal framework on sexual reproductive health in Kenya catalysed the promotion of ASRH in Siaya County?
- What factors influence CSOs' implementation of ASRHR interventions, particularly those linked to adolescent pregnancy, and how do they navigate challenges therein?
- What programmatic strategies have CSOs in Siaya County deployed towards the realisation of adolescent SRH rights in the context of adolescent pregnancy?

The study adopted a descriptive qualitative research design, using in-depth interviews as the main data collection strategy and reproductive justice theory as the theoretical underpinning. Seventeen civil society organisations implementing adolescent SRH programmes in Siaya County were interviewed; the data was analysed thematically. This chapter is structured as follows: Section 5.2 presents

the general conclusions drawn from the three research questions. Section 5.3 articulates this study's contribution to empirical, theoretical, and methodological knowledge. Section 5.4 presents recommendations for policy, practice, and future research. Section 5.5 evaluates the suitability of the theoretical and methodological framework and Section 5.6 provides a closing comment on the study.

## **5.2 GENERAL CONCLUSIONS**

This section reports on deductions drawn from the study's findings in terms of the stated research objectives. The literature review and the findings are compared in each of the sections below.

### **5.2.1 Juxtaposing robust national SRH policy and legal frameworks with the promotion of ASRH in Siaya County**

The data for this research question covers two research objectives, namely, an assessment of the internal and external factors that influenced ASRH programme interventions by civil society organisations and an interrogation of factors, policies and laws that contour civil society organisations' engagement in reproductive justice. Overall, Kenya has robust and progressive laws and policies that promote adolescent reproductive health and rights. Literature reviewed in Chapter Two and findings in Chapter Four indicated that the presence of these laws legitimised CSOs' programming on sexual reproductive health rights for adolescents at national and county levels. These policies and laws were framed from a rights-based perspective, foregrounding inclusion and non-discrimination in the provision of SRH information and services for all adolescents. The implementation of these frameworks, however, was problematic and curtailed by sociocultural biases held by policymakers, health service providers and, in some instances, CSO workers on issues such as - access to contraception, comprehensive sexuality education, abortion rights and the inclusion of sexual minorities. It can be concluded that the rights-based rhetoric found its way into

SRH policy frameworks, but that the implementation falls short of rights-based thresholds. Moreover, African feminists argue that African states' partial implementation of laws and policies is influenced by colonial and patriarchal capture. The states' work through policy makers, legislators and service providers as gatekeepers of colonial culture and legacies, all of which block adolescent reproductive autonomy (Tamale 2011).

The governance architecture of post-colonial and post devolution Kenya impedes the translation of progressive adolescent SRH policies into local implementation. This has resulted in the national government overseeing policymaking while the counties oversee the domestication of policies in their contexts including financing. The study illuminated the disconnect between national and county governments in steering the implementation of SRH policies related to adolescents. This was particularly visible from the lack of implementation of the right to SRH information through providing comprehensive sexuality education. The participants pointed to a lack of accountability since no department wanted to take the lead on contentious SRH issues like CSE. Furthermore, the study found that inadequate budgetary allocations for SRH services impeded their full implementation at the county level, given that in Kenya the planning and budgeting is a devolved function. This resulted in a vicious cycle of prejudicial attitudes regarding adolescent SRH , poor leadership, lack of political will to implement more contentious issues of SRH and CSE, and little advocacy to place these matters on the budget agenda for local implementation. Taken together, an African feminist reproductive justice perspective contends that patriarchy and colonial control was devolved to the county level (Mama 2007 & 2011). This would demand a two-pronged approach to normalise ASRHR as a key part of care and a collaboration between the policymaking and implementation agents to see these rights are acted upon.

The review of literature as reported on in Chapter Two, highlighted the contradictory policy and legislative frameworks that made it challenging for adolescents to access services, health service providers to provide services, and

activists to advocate for ASRHR. Specifically, the adolescent right to consent paradox emerged where contradictory legal and policy statements have been subject to individual interpretation and strategically deployed to perpetrate conservative attitudes and sustain accountability deficits (KELIN 2023; Aoko 2022). African centred reproductive justice scholarship contends that policy sufficiency does not translate to programmatic adequacy within African contexts. Ultimately, the implementation of adolescent SRH policies must accommodate nuance, including an appreciation and application of the concept of evolving capacities (Kangaunde & Skelton 2018).

### **5.2.2 Factors influencing CSOs' implementation of ASRHR interventions, particularly those linked to adolescent pregnancy**

This research question covered the study's objectives. Firstly, the study assessed those factors that influence ASRH programme interventions by CSOs in Siaya County. Secondly, the study investigated factors, policies and laws on CSOs' engagement with ASRH in Siaya County. The study found that funding influenced the capacity of civil society organisations to deliver on ASRH programme interventions. Programme funding was accessed through donor-funded consortium projects, short-term projects in collaboration with other CSOs and voluntary efforts by their members. These funding modalities were mostly short-term in nature, meaning that the sustainability of project activities and the overall impact of programmes were poor. Related to this is the fact that ASRH issues are complex, meaning that they require longer-term funding cycles and slow, transformative approaches. Literature reviewed in Chapter Two and findings from the interviews in Chapter Four affirmed that SRH activities are short-lived and implemented in piecemeal ways, making it challenging to establish their impact (Beckwith et al. 2024; Chandra-Mouli et al. 2015; Chandra-Mouli et al. 2021). At the same time, the study affirmed that donors influence was deployed at three levels, that all together fostering colonial hierarchy and patriarchal tendencies which subordinated CSO programming. Specifically,

1. They prescribed programme designs in terms of the type of activities and geographic coverage. These prescriptions did not always respond to the needs of adolescent girls.
2. Donors placed stringent requirements on CSOs who applied for funding. The CSOs interviewed in the study confessed to having limited financial management capacities, and this prevented them from applying for funding (Abiodun et al. 2024).
3. Donors ascribed to technocratic programming approaches that presumed a linear process to achieve project outcomes. With limited room for adaptive management, CSOs failed to achieve lasting change (Gutheil & Koch 2023; Gutheil 2020, 2021).

These findings illuminated the extent to which NGOisation influenced SRH programming and its impact on gender transformation (Lang 2022). CSOs adoption of short term and measurable activities was influenced by the need to survive funding cycles and compliance to donor prescriptions. An African feminist reproductive justice lens contends that the NGOisation of SRH interventions simplifies adolescent SRH. These findings illuminate the extent which NGOisation influenced SRH programming and its impact on gender transformation (Lang 2022). CSOs adoption of short term and measurable activities was influenced by the need to survive funding cycles and compliance to donor prescriptions. An African feminist reproductive justice lens contends that the NGOisation of SRH interventions simplifies adolescent SRH needs, yet they operate in deeply entrenched colonial and patriarchal systems. Resultantly, the interventions failed to address systemic failures that exacerbate adolescent reproductive oppression (Mama 2011; Ross 2017).

The study also found that CSOs' operations and geographic footprint were influenced by their legal registration. In most cases, the CSOs registered as community-based organisations were confined to smaller geographic locations, yet adolescents' SRH needs transcended borders. In Chapter Two, governmentalism was identified as a barrier to civil society engagements globally,

and in this study, governmentalism presented itself in the form of laws, policies and administrative actions that CSOs had to comply with to be in right standing with the government (Matelski & Woensdregt 2024; Glasius et al. 2020). From an African feminist reproductive justice lens, not only is governmentality an administrative bureaucracy, but it also speaks to the legacies on colonisation where compliance to government policies was a form of control and regulation of citizens (Tamale 2011).

Furthermore, stringent donor rules and regulations reproduced colonial hierarchies where, CSOs with stronger capacity were preferred, a scenario that entrenches unequal power relations and diminished agency on the part of local CSOs (Katisi et al. 2016). Such requirements also depoliticised CSOs work as they heavily invested in being compliant or being the right fit. African feminist thought and reproductive justice principles posit that by CSOs moving away from the social justice focus, and when they overly focus on managerialism, they fail to represent their constituency, in this case adolescent girls leading to sustained adolescent reproductive oppression. Related to this was competition that emerged as a challenge faced by the participants. The study found that most of them conducted similar activities, targeting the same communities and often resulting to duplicated efforts. Donor's focus on high and quick quantified impact influenced how CSOs design and deliver project activities and a greater adoption of non-transformational interventions (Mulder 2023).

The study found that stakeholder conflict was a challenge, these conflicts were majorly among CSOs jostling for programme participants and with government partners as it related to financial allowances offered during project implementation. From an African feminist reproductive justice perspective, competition and conflict among CSOs implementing SRH interventions erodes solidarity and collective care, all of which are critical in dismantling patriarchal systems and processes (Mama 2020). Government stakeholders' preference to working with CSOs providing higher financial allowances reduces adolescent SRH needs and gaps to products that can be monetised, thereby defeating the

projects' purpose (Ferati et al. 2023). It must be noted that competition for programme participants and financial resources is an effect of donors' push for evidence-based impact within short project cycles that is removed from the complexities of structural gaps that block access to SRH services (Ampofo et al. 2022). Therefore, competition should not only be viewed as a programmatic challenge but recognised as a structural mechanism that weakens solidarity, collective action and care (Tamale 2011).

Smaller CSOs struggled to keep up with the bigger ones, as stakeholders preferred to work with bigger CSOs with larger budgets who can afford these projects. The study supports previous research indicating that competition for funding and financial resources is commonplace among civil society organisations (Koch & Rooden 2024; Matheka & Nzomo 2023). Fierce competition for both donors and stakeholders are therefore nothing new in the CSO space, however, it does not mean that the ferocious rivalry must be normalised. If the national government is serious about seeing its progressive SRHR policies come into fruition via local implementation, then solutions must be found for destructive competition for funding and stakeholders. From an African feminist thought, competition enabled hierarchy, power imbalance and exclusion of smaller grassroots led organisation, who, in accordance with the reproductive justice theory, would be unable to organise and collectively advocate for adolescent girls' sexual reproductive health and rights.

The sociocultural context was found to influence CSOs' ASRH programme interventions. Specifically, CSOs found it challenging to implement holistic and inclusive ASRH interventions such as advancing the SRH rights of sexual minorities and advocating for abortion rights, as these were deemed to be culturally unacceptable. At the same time, their programming context was found to be highly infused with specific religious ideas that govern decision-making about health. This resulted in a low uptake of SRH services, such as contraception as well as significant stigmatisation of sex and sexuality-related issues. This finding aligns with other studies suggesting that, despite progress in

advancing adolescent SRH post-ICPD, morally contentious issues remain widely frowned upon (Sen et al. 2019).

Furthermore, gender and power dynamics influenced by the sociocultural realities of Siaya County emerged. The study revealed that adolescent girls were unable to participate in ASRH activities organised by CSOs or access SRH information and services without obtaining spousal consent for married adolescents and parental consent for those who were unmarried. To navigate this challenge, CSOs embarked on spousal engagement activities as well as outreach to parents, who they viewed as a critical social support to the adolescent girls. The repressive socio-cultural context was reinforced by a patriarchal and protectionist legal and political context carried on from colonial legacies and intensified by religious dominance (Tamale 2011). Observably, CSOs interventions were inadequate in terms of navigating socio-cultural gaps, as they focused on individualised activities as opposed to political and transformative work that challenged systemic barriers and status quo.

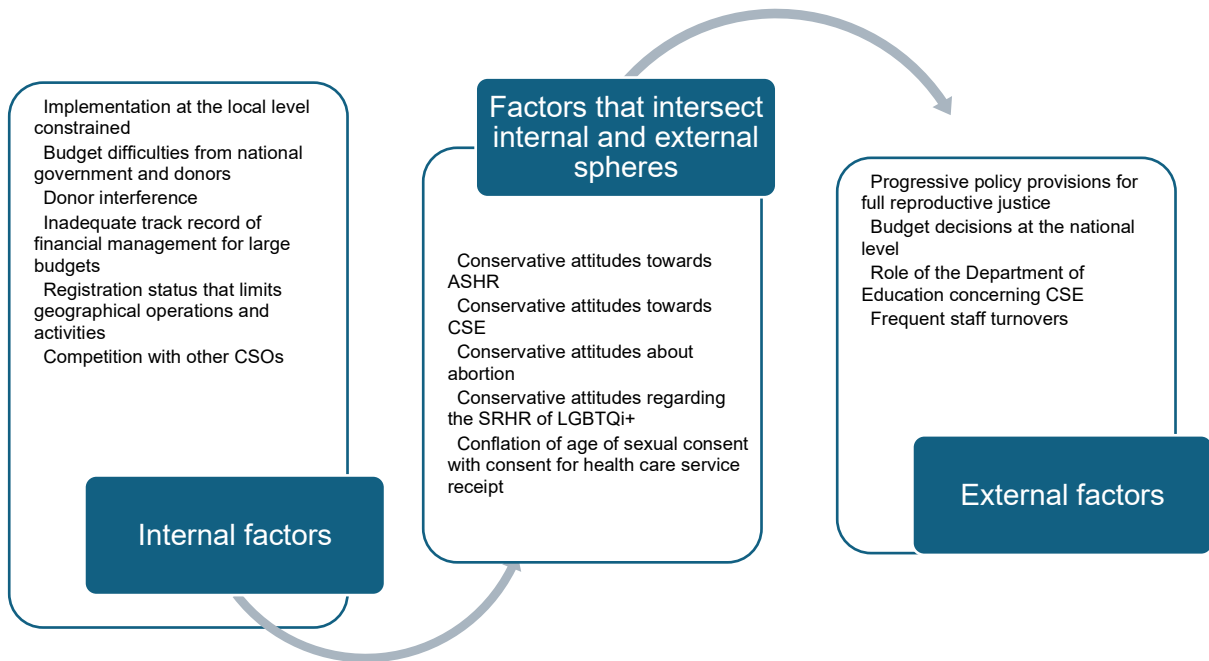
The study found that structural issues hampered CSOs' work. It was noted that frequent family planning commodities stockouts, at the health facilities, was a challenge. Even though CSOs worked towards sharing information on contraception, adolescent girls failed to access family planning commodities due to total unavailability and in some instances, most young women did not find their preferred contraceptives. In addition, it was found that health service providers hindered access to SRH services by imposing their values around sex and contraception on adolescent girls. CSOs indicated that they navigated this challenge through capacity strengthening of health service providers, however, frequent staff transfers impeded continuity. Literature reviewed in Chapter Two indicated that when health service providers were trained on values' clarification and adolescent sexual reproductive health, adolescents reported improved attitudes (Gillespie et al. 2022; Ninsiima et al. 2021). Whilst a focus on capacity of providers and family planning value chains is important, an African feminist reproductive justice lens calls for a power analysis with a view to understanding

whose interests these groups serve. Health service providers are a gatekeeper on patriarchy and governmentality within the health system; they enable the subjective translation of policy to practice (Tamale 2011). Similarly, broken family planning value chains should be viewed as a lack of the state's accountability to adolescent girls' and women, not just as a programmatic inconvenience.

Overall, the internal and external factors discussed above constitute a condition of structural entrapment where CSOs operating in Siaya County are simultaneously mandated to advance adolescent girls' reproductive justice, constrained by the donors who fund them, regulated by a state that limits their mandate and reach, and embedded in sociocultural environments that resist their most transformative intentions. This finding extends existing literature on governmentality and civil society by demonstrating that structural entrapment is not a peripheral challenge but the defining condition of CSO engagement with adolescent girls' SRH in rural Kenya (Glasius et al. 2020; Matelski & Woensdregt 2024).

The study mapped the factors that contour the CSOs' implementation of ASHR services, and the ability of the CSOs to navigate these barriers was often restricted by budgets, need for obtaining permissions, and conservative attitudes. These issues are depicted in Figure 5.1 below.

**FIGURE 5.1: INTERNAL, EXTERNAL AND FACTORS THAT INTERSECT THESE SPHERES TO SHAPE CSOS' INTERVENTIONS IN ASHR MATTERS**



Source: Author (2025)

### **5.2.3 Programmatic strategies of CSOs in Siaya County towards the realisation of adolescent SRH rights**

This research question covered the research objective that evaluated the effectiveness of the strategies deployed by the CSOs. The study, therefore explored the types of interventions implemented, their effectiveness from the CSOs' perspectives and their alignment with the tenets of reproductive justice.

In terms of the types of interventions, MHH emerged as a critical area of ASRH programming. Interventions targeted individual girls through the distribution of sanitary towels, both for the sake of human dignity and to curb potential exploitation by male partners who offered to purchase such personal products in exchange for sex. This finding was aligned to Sommer et al. (2021); Phillips-Howard et al. (2016); Oruko et al. (2015) whose studies found that girls from poor backgrounds were vulnerable to sexual exploitation as they sought money to purchase sanitary pads. Research further confirms that these girls had increased vulnerability to HIV/AIDS transmission, unintended pregnancy and school dropping out (Haider 2023).

In addition, these MHH initiatives leaned heavily on training about hygiene management during menstruation. This was a suitable node for first exposure to wider ASRH services and information. However, the study showed that these interventions did not address systematic issues around MHH, such as financing to ensure sustainability - a finding that resonates with Sommer et al. (2021) who argue for longer-term interventions. The activities implemented by the CSOs tended to address an immediate need for sanitary products, with little more beyond that. Based on this, the distribution of sanitary pads as the MHH programming strategy was ineffective from a sustainability and transformation perspective.

From a reproductive justice perspective, the paramountcy of individualised interventions reveals a tension between the immediate needs of adolescent girls and the structural causes of their reproductive vulnerability. Furthermore, distributing sanitary pads without addressing the economic conditions that make adolescent girls susceptible to transactional sex constitutes a partial and inadequate response to reproductive oppression. Another popular intervention type focused on the prevention and response to GBV, specifically due to concerns about adolescents' exposure to sexual violence and early marriage. Akudolu et al. (2023) posit that GBV is enabled by unequal power relations between men and women and that interventions addressing the same were

crucial in safeguarding the SRH of women. Literature points out that GBV exposed adolescent girls to unintended pregnancies which may require abortion services in case they chose not to keep the child (Acharai et al. 2023). This study revealed the direct connection between GBV and adolescent SRH by articulating specific types of GBV in the study participants areas of operation.

CSOs implemented activities such as community sensitisation, reporting, and referrals, as well as advocacy for the enactment of laws to curb GBV in the county. The CSOs' advocacy sought to secure political commitment from leaders to ensure budget provisions for activities that responded to GBV, particularly the setting up of rescue centres. This finding is aligned to Mangwana, Omaso, Wilson & Tulay (2023) who outline the role of CSOs, as that of advocacy at local levels and policy influencing at the political level as they promoted social change. The strategies under the prevention and response to GBV were on a continuum targeting individuals, communities and government structures. Policy and budget advocacy were effective strategies as they were domiciled in law and administrative actions that would ensure continuity even beyond funding cycles.

Activities targeting individuals and communities for behaviour change, however, were ineffective, as they could not be achieved at scale without funding and that social cultural changes required time, which CSOs' programme interventions could not guarantee due to the short-term nature of their projects. Literature shows that professionalisation of civil society organisations led to an increased emphasis on quantification of immediate results and less of longer-term outcomes, watering down the essence of transformative programming (Arda & Banerjee 2021). An African feminist reproductive justice paradigm posits that CSO programming must address structural causes of gender-based violence that impede bodily autonomy of adolescent girls (Keith et al. 2023). Additionally, the interventions implemented by the CSOs understudy substituted service vacuums left by the state (Wolch

1990). In so doing, they relegated their role as advocates and social change makers.

Overall, the types of interventions spanned from community outreach and advocacy to service provision. CSOs ensured that there were platforms for disseminating SRH information, targeting community members and adolescent girls. CSOs were involved in budget advocacy and citizen-driven processes, although, they also played a watchdog role through conducting research and internal advocacy, specifically by being active in technical working groups. The study found that such technical working groups were effective in terms of influencing the government agenda on SRH-related issues, however, decision-making, central to policy development was fully delegated to the county executive, meaning that the invited spaces for advocacy were limited.

The findings also highlighted the CSOs' securitisation approach to integrating adolescent pregnancy into the county's development agenda, which promoted neoliberal connotations of the individual girl as a locus for economic development. In so doing, CSOs obscured the systemic failures that hindered the ability of adolescent girls to engage in sexual activity, without the apprehension of unplanned pregnancy. Hence, the securitisation of adolescent pregnancy did not provide young women with alternatives to avoid childbirth. In summary, it can be concluded that the interventions had some effectiveness for advocacy, but that this can and should be expanded to ensure improved ASRH services.

In terms of the alignment with reproductive justice, an important finding was that the intended target stakeholders of the programmes offered by the CSOs were the adolescent girls themselves. The participation of adolescent girls in programme design and implementation emerged as a required key activity. This was mostly evidenced in donor-funded projects because such participation was a requirement from donors for programme design, as discussed in Section 5.2.1. This finding challenges the simplistic celebration of adolescent participation in CSO programming literature. This study found that where participation is donor-

driven rather than organically cultivated, and where it is sustained by unpaid volunteer labour rather than structural investment in young women's agency, it risks reproducing the very instrumentalization of adolescent girls that reproductive justice theory identifies as a core site of reproductive oppression. Through a reproductive justice lens, meaningful participation demands that adolescent girls be treated as rights-holding agents rather than passive beneficiaries. This requires moving beyond 'giving them a voice' toward providing the legal protections and institutional recognition necessary for them to lead programme design.

Based on the analysis above, three patterns emerged, Kenya's progressive sexual reproductive health commitments enshrined in law, affirmed in policy, and operationalised through civil society consistently fail to materialise into transformative outcomes for adolescent girls in Siaya County. The failure to translate rights-based aspirations to SRH reality is a product of the interaction between sociocultural resistance, policy failure and CSO incapacity. Furthermore, a governance structure that devolves responsibility without resources, a donor architecture that funds activities without transformation, and a patriarchal sociocultural context constrains the most redistributive dimensions of reproductive justice programming. Understanding this interaction is the analytical core of this study's contribution to Development Studies and to reproductive justice scholarship in Africa.

### **5.3 RECOMMENDATIONS**

Based on the findings, the next sections offer recommendations for policy, practice and further research.

### **5.3.1 Recommendations for policy**

This study found that there was an abundance of policies on adolescent sexual reproductive health in Kenya, although their implementation was challenged at the county level. From the research, it is evident that SRH is broad and different sectoral policies contribute to the highest attainment of health as envisaged by the constitution. One of the policy gaps is the misalignment of standards set by the different policies. An instance of this is that the age of maturity is 18 years old, and the capacity to consent to sex is 18 years, however, this has been conflated with the capacity to consent to services, and as a result, health service providers are unable and unwilling to provide SRH services required by adolescents. This is further compounded by the *National Reproductive Health Policy 2022-2030*, which stipulates that children and young people up to the age of 21 years require parental consent to access SRH services (Government of Kenya 2022). It is recommended that SRH policies related to adolescents implement the principle of evolving capacities, this ensures adolescent girls are supported depending on their individual needs and capacities.

Another policy recommendation relates to health financing. Evidently, most adolescent girls in Siaya access healthcare through public healthcare facilities, however, access to SRH services is often paid for out of pocket of the users. Kenya has centralised UHC in its healthcare plans, although prioritisation for all SRH services is still downplayed. It is recommended that SRH services under the essential care package be prioritised and budgets allocated towards human resources, contraceptives, post-abortion care and comprehensive sexuality education.

### **5.3.2 Recommendations for practice**

The study found that civil society organisations adopted programme strategies that had a blend of neoliberal and risk-based perspectives with a touch of rights-

based and social justice viewpoints mixed in. At the same time, the CSOs variably targeted adolescent girls with disabilities and sexual minorities, exacerbating the inequalities that already exist in the provision of services to these groups. It is recommended that CSOs integrate social justice and feminist lenses in their programme design and implementation. The study also affirmed that most of the interventions were financially dependent on and prescribed by donors with short implementation periods. The risks with such dependencies include loss of funding due to changes in donor priorities and irrelevant interventions, including those that depoliticise sexual and reproductive health. It is recommended that CSOs diversify their resource mobilisation strategies to cover funders who are aligned with reproductive justice principles as opposed to being clamped down by neoliberal development policies and funding architecture that prefer technocratization, medicalisation, and commodification of sexual and reproductive health rights.

### **5.3.3 Recommendations for future research**

#### **5.3.3.1 Disability Inclusion**

This study found that adolescent girls with disabilities were an underserved population that required specialised support. It is recommended that future research focus on how adolescent girls with disabilities access SRH services in Kenya and how the health system supports or impedes their right to health.

#### **5.3.3.2 UHC and SRH services**

Health financing emerged as a pertinent issue in access to SRH services based on donor funding and domestic health financing. It is recommended that further research into county prioritisation processes around SRH during budgeting cycles, be undertaken.

## **5.4 EVALUATION OF THE SUITABILITY OF THE THEORETICAL AND METHODOLOGICAL FRAMEWORK**

This study was framed on the reproductive justice theory that was discussed in Chapter Two, where the history and key tenets of the theory were deliberated. The theory was used to frame the research questions, data analysis, and discussion of findings. Fundamentally, reproductive justice theory originated from the Black feminist movement in the US. It sought to address the exclusion of women of colour in sexual and reproductive health policies and practices and to disrupt the mainstream narratives on individual agency without due consideration of systemic factors that block women from accessing sexual and reproductive health information and services. As such, this theory has found itself integrated into SRH practices and policy directions globally, however, studies have found that its application in empirical research has been low (Morison 2021; 2023).

The application of the reproductive justice theory is limited in African contexts, especially in the context of civil society organisations' engagements. To sufficiently apply the reproductive justice theory in the Kenyan context, a critical examination of African feminist thought that conceptualises gender, power and bodily autonomy was integrated. The study drew from the works of Mama (2007; 2011) who showcases the complexity of African women's identities through colonial, neoliberal governance and patriarchy lens. Mama's work remains critical of how African feminist scholarship is deterred by dominant neoliberal development discourses at the global level. This lens was useful to the study as it sought to establish how internal and external factors influenced CSOs adolescent SRH interventions. At the same time, the study integrated Tamale's discourse on African sexuality and feminist jurisprudence as a supporting theoretical lens. Tamale (2011) contends that protectionist laws in Africa are an extension of colonial and religious patriarchy, reproducing and sustaining reproductive oppression of African women and girls. By integrating Tamale's thesis in the study, the role of law and governmentality was identified as a determinant of adolescent SRH rights. In addition, this study invoked Oyewumi's

(1997) works that problematise the universality of gender as a factor in African social organising. Her thesis expands focus to other determinants of social organising to include seniority, and a focus on community relations as opposed to individualism. Oyewumi's perspective was critical to the study given the Eurocentric nature of reproductive justice's origins where it was presumed that individual agency was paramount, the study expanded its perspectives to theorise the role of community relations in the advancement of reproductive justice. Altogether, African feminist thought contextualised and refined the reproductive justice theory and the theoretical convergence offered a relevant diagnostic ground for interrogating CSOs engagements in advancing adolescent SRH in Siaya county.

Through this study, it is evident that reproductive justice theory is applicable as a framework for interrogating CSOs' engagements given the multiplicity of their mandates. These include the role of CSOs in social and political change through advocacy; the operationalising of rights-based approaches and their mandate in highlighting the plight of excluded and marginalised populations. At the same time, the literature review in Chapter Two and the findings as detailed in Chapter Four reveal that adolescent pregnancy was pathologised, with approaches towards curbing it, often taking a risk-centric approach. In addition, policies and programme interventions take a neoliberal stance, targeting the individual girl, as opposed to addressing systemic issues that promote the right to have a child, the right not to have a child, and the right to have a child in safe environments.

Reproductive justice theory as used in empirical research disproportionately focuses on abortion rights, whereas this study employed the theory to analyse other components of SRH, including contraception and access to information. In addition, the theory is anchored in the principles of human rights, which assume the universality of rights and cultural relativism. Critiques have noted that the assumption of the universality of rights can be said to advance Eurocentric perspectives (Abdulrahman & Mohammed 2023; Heüer 2019; Saghaye-Biria 2018). The study found that the participants from the sampled CSOs were able

to identify what was considered as violations of rights, which at times were contrary to prevailing conservative perceptions on consent and CSE. The tensions between rights and context, therefore, remain unresolved.

This study adopted a qualitative approach, relying on in-depth interviews that enabled the researcher to understand the lived experiences of CSOs in ASRH programming as opposed to making generalised conclusions. The contribution of knowledge therein is on the relevance of in-depth interviews using reproductive justice theory. Based on the application of this theory, this study argues that exclusion and marginalisation in the context of adolescent pregnancy as a sexual and reproductive health issue, can be framed from an age perspective. Laws and policies in Kenya identify persons under the age of 18 as children. The principle of evolving capacities as discussed in Chapter Two is scarcely applied. As a result, adolescents are denied SRH information and services as envisaged by the Constitution of Kenya as pertaining to the right to health, and this infringes on the agency of young people to make informed decisions about their bodies.

Additionally, sexual orientation and disability emerged as individual markers that promoted further exclusion and marginalisation. The study found that most CSO interventions excluded sexual minorities, as sociocultural norms in Siaya County abhorred same-sex relationships, and CSOs had to be careful not to be deemed as LGBTQI+ sympathisers. At the same time, CSOs indicated that SRH services did not address the needs of persons living with disabilities, due to their limited technical capacity.

Intersectionality is a key tenet of the reproductive justice theory. The study found that adolescent pregnancy as a component of sexual and reproductive health intersects with multiple issues:

- Kenya's governance structure was implicated as blocking adolescent reproductive justice due to the devolved system of governance where the national government oversees policymaking while county governments take

the lead on domesticating the policies to their contexts, financing essential services including health care, as well as, conducting quality assurance. The study found that there were instances where laws and policies were not domesticated at the county level, and this was a prerequisite for budgetary allocations. Moreover, a lack of accountability for SRH-related issues, for example, information, emerged as a stumbling block because the Ministry of Education and Ministry of Health at county levels did not agree on what was age-appropriate comprehensive sexuality education.

- Health financing needs to be reviewed from a universal health coverage perspective, which the national government has integrated into all its sectoral plans. UHC, however, is actualised at the county level, and this includes financing of health services via government-run insurance, which was found to be exclusionary to adolescent girls' needs. Overall, literature around UHC has argued that priority-setting is a general challenge, as well as the prioritisation of some elements of ASRH, like abortion care and comprehensive sexuality education being ignored (Chalkidou et al. 2016; Lauer, Rajan & Bertram 2017; Mbau et al. 2023).

Reproductive justice theory takes on a human rights perspective that combines three rights, namely, the right not to have a child, the right to have a child, and the right to have a child in safe environments. From this study, the right not to have a child via contraception and abortion was problematic. CSOs were unable to promote this right due to legal constraints; for instance, policies on ASRH require consent of a parent or guardian to dispense these services. At the same time, misinformation on contraception and pushback on abortion care meant that CSOs were not fully covering this right. Attending to menstrual health and hygiene was a programmatic intervention carried out by most of the respondents with the aim of reducing instances of sexual exploitation that would eventually lead to unplanned pregnancy. Based on this finding, it could be argued that MHH programming was a mechanism for blocking unplanned pregnancy. The denial of contraception, comprehensive sexuality education, and abortion services

obstructs adolescent girls' body autonomy and is tantamount to reproductive oppression.

Only one of the CSOs in this study was involved in interventions around the right to have a child. In this instance, they supported adolescent girls through antenatal and postnatal care. The rest of the study participants provided SRH information, including where to access pre- and ante-natal services. Notably, the CSOs targeted married and unmarried in-school and out-of-school adolescents, but their programming packages were not necessarily tailored to suit the needs of specific groups. Finally, the right to parent in a safe environment was covered in some CSO activities that focused on supporting adolescents who are mothers to return to school. These activities included direct support with school fees and scholastic materials as well as mediating conflict between parents and mothering adolescents.

These great initiatives showed promise, yet it also emerged that adolescent girls failed to access their right to SRH due to political impediments, and as such, reproductive justice theory offers a relevant framework for political analysis. Through its application, this study is as much an academic product as it is a tool for resisting reproductive oppression.

## **5.5 CONCLUSION**

This study explored the contribution of CSOs to adolescent reproductive justice in Siaya County, Kenya. The findings indicated that Kenya has a robust legislative and policy framework that enables programming on adolescent sexual and reproductive health. The realisation of these sexual and reproductive rights, however, was impeded by conscientious biases stemming from sociocultural perspectives around gender roles, sex, sexuality and children. Moreover, the operationalisation of these rights requires financing, availability of competent healthcare service providers and relevant services that respond to the needs of adolescent girls. The study further indicated that CSOs deploy many strategies

in the SRH interventions, including promotion of adolescent girls' participation in projects, prevention and protection against gender-based violence, menstrual hygiene management, community outreach and advocacy, and policy advocacy. These interventions were mostly focused on access to SRH information as well as services. Critically, the study was framed from an African feminist reproductive justice perspective which shifts focus from individual choices to identifying and challenging systemic issues at the micro and macro levels that exacerbate reproductive oppression in adolescent girls.

Throughout this study, barriers to adolescent reproductive justice were identified, most prominently a lack of political commitment in implementing SRH policies and legislation at a county level, limited funding from donors and government, and legislative restrictions on where CSOs are allowed to work. The study revealed that sustainability of adolescent SRH interventions was a great challenge due to the overreliance on donor funding, short-term and piecemeal interventions, as well as donor prescriptions on SRH programmes. This study was framed using an African feminist reproductive justice theory, data generated from in-depth interviews and findings. This not only provided policy recommendations but also expanded the application of the reproductive justice theory in Kenya and in empirical research.

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## APPENDIX A: ETHICAL CLEARANCE CERTIFICATE



### COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

29 August 2022

Dear Mrs Hellen Okoth Mala Owiti

NHREC Registration # :  
Rec-240816-052  
CREC Reference # :  
53315669\_CREC\_CHS\_2022

**Decision:**  
**Ethics Approval from 29 August 2022  
to 29 August 2023**

**Researcher(s): Name:** Mrs. H. O. M. Owiti  
**Contact details:** [53315669@mylife.unisa.ac.za](mailto:53315669@mylife.unisa.ac.za)  
**Supervisor(s): Name:** Prof G.E. du Plessis  
**Contact details:** [Dplesge@unisa.ac.za](mailto:Dplesge@unisa.ac.za)

**Title: CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT IN ADVANCING  
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A  
CASE OF SIAYA COUNTY**

**Degree Purpose: PhD**

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The *low risk application* was reviewed by College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.






The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the



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## APPENDIX B: NACOSTI RESEARCH LICENCE

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Ref No: 148181	Date of Issue: 23/September/2022
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<b>This is to Certify that Ms.. Hellen Owiti of University of South Africa, has been licensed to conduct research in Siaya on the topic: CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT IN ADVANCING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KENYA: A CASE OF SIAYA COUNTY for the period ending : 23/September/2023.</b>	
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## **APPENDIX C: INTERVIEW GUIDE**

### **Research title: Civil Society Organisations' Engagement in Advancing Adolescent Sexual Reproductive Health Rights in Kenya: A case of Siaya County**

Researcher: Hellen Okoth Mala Owiti

Student Number: 53315669

Ethics clearance reference number:

Research permission reference number (if applicable):

Date of interview:

#### **Section A: Background Information**

1. List the selected CSO's name
2. What is your role here at (name of CSO)?
3. What is your organizations' mandate on issues related to adolescent SRHR?
  - o Probe range of services
  - o Probe nature of services
  - o Probe adolescent services
  - o Probe flagship programmes
  - o Probe funding
  - o Probe the gender profile of the staffing
  - o Probe participation/consultation with adolescent girls (participatory interventions and feedback loops)
4. In which areas of Siaya County are you implementing ASRHR programmes?

#### **Section B ASRHR Programming**

1. What interventions do you deploy regarding adolescent pregnancy? o Probe: What are your CSOs' successes?
  - o Probe: What are any barriers to full reproductive justice?
  - o Probe: What is your understanding of adolescent reproductive justice? Is it different from population control narratives targeting adolescent women? How?

o Probe: From your CSO's website, I have found the following description of your services (read from notes). How does this capture the norms and values of your organization?

o Probe: Any differences between the official discourse of the CSO and the interviewees' personal values and norms?

2. Which policies or legislative frameworks on SRH undergird the implementation of your programme interventions? o Probe: Are these policies and legislative frameworks supportive of your work? How?

o Probe: Do any of these policies and legislative frameworks prevent what your CSO wants to achieve? How?

o Probe: What are the gaps in the policies or legislation?

o Probe: What are the gaps in implementation?

o Probe: To what extent are your interventions curtailed by the prescription of donors or funders?

3. What challenges do you face in the delivery of your mandate? o Probe: Give me an example of a challenge experienced most recently (probe if these are socio-economic, funding-related, due to socio-cultural barriers, religious convictions, patriarchal gender values, funding, lack of political will, the COVID-19 pandemic)

o Probe: How do you navigate such challenges?

o Probe: How do you monitor successes?

o Probe: To what extent do adolescent women participate, or shape, your interventions?

4. What opportunities do you foresee in advancing SRH rights of adolescent girls? o Probe: What would you like to see change in the next 5 years?

o Probe: Who should drive this change?

o Probe: What would make you continue in your work?

o Probe: What will make you give up on your objectives?

5. Who are the major stakeholders in helping you achieve the goals for ASRHR?

Thank you for your participation. Are there any aspect that you would like to add?

Would you be willing to participate in a follow-up workshop during which I will summarize the main themes from my interviews?

Yes – please get contact details

No – thank you for your kind participation.

## APPENDIX D: PARTICIPANT INFORMATION SHEET



Research title:	Civil Society Organizations' Engagement in Advancing Adolescent Sexual Reproductive Health Rights in Kenya : A case of Siaya County
Researcher:	Hellen Okoth Mala Owiti
Student Number:	53315669
Ethics clearance reference number:	
Research permission reference number (if applicable):	
Date	

### Dear Prospective Participant

My name is Hellen Okoth Mala Owiti, and I am doing research with Gretchen Du Plessis, a Professor in the Department of Development Studies towards a Doctor of Philosophy PhD the University of South Africa. We are inviting you to participate in a study entitled 'Civil Society Organizations' Engagement in Advancing Adolescent Sexual Reproductive Health Rights in Kenya: A case of Siaya County'

### WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out CSOs contribution in the realisation of adolescent reproductive justice in Kenya. Specifically, assessing factors that influence CSOs' implementation of ASRHR interventions, particularly those linked to adolescent pregnancy and how they navigate challenges therein. The study looks at the programmatic strategies of CSOs in Siaya County to realize adolescent sexual and reproductive health rights in the context of adolescent pregnancy.

### WHY AM I INVITED TO PARTICIPATE?

You are invited to participate in this study as your organization is involved in services directed at adolescent sexual reproductive health rights in Siaya county. I have verified this by looking at the information shared on your CSO's website and by speaking to the Siaya County SRH Coordinator and the SRHR Alliance Kenya. The study targets 30 participants from CSOs.



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**APPENDIX E: INFORMED CONSENT FORM  
CONSENT TO PARTICIPATE IN THIS STUDY**

I, \_\_\_\_\_ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the <insert specific data collection method>.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print)

Participant Signature.....Date.....

Researcher's Name & Surname.....(please print)

Researcher's signature.....Date.....

## APPENDIX F: LETTER FROM THE LANGUAGE EDITOR

### PROOF OF EDITING

22 June, 2025

This is to certify that I, Dr P Kaburise, have proofread the thesis titled - **CIVIL SOCIETY ORGANISATIONS' ENGAGEMENT IN ADVANCING ADOLESCENT REPRODUCTIVE JUSTICE IN KENYA: A CASE OF SIAYA COUNTY** - by Hellen Okoth Mala Owiti (student number: 53315669). I have indicated some amendments which the student has undertaken to effect before the final thesis is submitted.



Dr P Kaburise (0794927451/ 0637348805; email: [phyllis.kaburise@gmail.com](mailto:phyllis.kaburise@gmail.com))

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Dr P Kaburise: BA (Hons) University of Ghana (Legon, Ghana); MEd University of East Anglia (Cambridge/East Anglia, United Kingdom); Cert. Teaching English as a Foreign Language (Cambridge University, United Kingdom); Cert. English Second Language Teaching, (Wellington, New Zealand); PhD University of Pretoria (South Africa).

## APPENDIX G: FIRST PAGE OF THE TURNITIN REPORT

### Similarity Report

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